Chemist&Druggist
The Newsweekly for Pharmacy

C&D

6 March 2004

Funding must be fair, PSNC tells minister

Spring draft for NI primary care strategy

J&J acquires Merck's OTC stake in Europe

Coming of age: No Smoking Day turns 21

All nasal decongestants contain preservatives

Right?

Wrong. The truth is, there is a modern nasal decongestant spray that doesn't contain a preservative. Because research has shown that preservatives like benzalkonium chloride may cause sensitisation.[1]

In Germany, researchers Deitmer and Scheffler concluded that a preservative-free formulation would be preferred.[1] And in Germany preservative-free Nasivin has become a significant pharmacy product.

Now preservative-free Nasivin is here in the UK. Containing oxymetazoline, you know a Nasivin recommendation should be effective. But beyond that, customers will appreciate the fact that Nasivin is preservative-free, has just twice daily dosing, and can be used for up to 14 days continuously.

Preservative-free nasal deconges

NASIVIN **Presentation:** 10ml Spray contains Oxymetazoline Hydrochloride Ph Eur, 0.05% w/v. **Indications:** For the relief of nasal congestion associated with disorders of the upper respiratory tract including infective and allerg sinusitis, naso-pharyngitis and coryza **Dosage and Administration:** Adults and children over 6 years, spray once into each nostril every 8-12 hours. Not recommended for children under 6 years of age **Contraindications:** In pa known hypersensitivity to sympathomimetics. In patients receiving monoamine oxidase inhibitors or within 14 days of stopping such treatment. In acute coronary disease, cardiac asthma, hyperthyroidism, or closed-angle **Precautions:** Continuous therapy should not exceed two weeks. NASIVIN SPRAY should not be used in pregnancy unless considered essential by the physician **Undesirable effects:** Prolonged use may cause rebound vasod chemical rhinitis **Overdose:** No experience of overdose, but supportive measures would be the appropriate treatment. Legal **Category:** GSL. **Recommended Retail Price:** 10ml £3.45. **Product Licence Number:** PL 019 **Product Licence Holder:** Seven Seas Limited, T/A Merck Consumer Health, Hedon Road, Marfleet, Kingston upon Hull, HU9 5NJ **Date of Preparation:** Dec-03. **References: 1.** Data on File, 2000. Expert Report on the Clinical Docu

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Regulars

C&D company details

As part of an internal restructuring on March 1, 2004, the business and contracts (including subscriptions) of CMP Europe Limited, Property Media Limited, The Builder Group Limited and CMP Information Limited were transferred to a legal entity which has been renamed CMP Information Limited.

The new CMP Information Limited is now the Data Controller under the Data Protection Act

Fair funding needed, Andrews tells minister

PSNC chairman Barry Andrews has told health minister Rosie Winterton that the new pharmacy contract must be properly remunerated.

"Current funding arrangements are unfair. Future funding must be fair," he told the minister in front of 600 guests at PSNC's annual dinner on Monday evening.

"We are all agreed on the need for fair funding. I say that just after the Department of Health has imposed a thoroughly unsatisfactory remuneration settlement on community pharmacists this current year; the latest in a long line of unsatisfactory outcomes over many years."

Mr Andrews added: "The new contract must bring with it a new funding system, one that fairly rewards quality and service, rather than the current system that under-rewards volume-based work. And that will be good not just for community pharmacists but for patients and the NHS.

"Community pharmacists are willing to invest in their pharmacies, and to be judged on the quality of the services they provide. But these NHS services must attract fair funding. Without it there is simply no business case for investment."

Mr Andrews pointed out that £0.5 billion could be saved every year if just a third of the patients who go to the GP with a minor ailment went instead to a pharmacy. He called for a nationally co-ordinated approach to minor ailment services, but warned that access should not be based on ability to pay.

"Pharmacists should be able to provide prescription charge exempt patients with advice and non-prescription medicines to treat self-limiting complaints, all on the NHS. That way, the NHS remains equitable and accessible for all."

The delay in the Government's implementation of changes to the control of entry regulations prompted Mr Andrews to warn that the resulting changes should work for patients and not result in the closure of local pharmacies, especially as the new contract was approaching.

"Community pharmacists need to plan on the basis of stability and certainty, and to deliver the new contract they will have to make additional investment in their pharmacies. They are hardly likely to do that if the changes to control of entry create volatility.

"And I hope you, minister, will agree that if the changes you plan to introduce risk destroying precious patient services, it's not too late to think again."

Minister hints at problems over control of entry

Health minister Rosie Winterton has hinted at difficult times ahead over the implementation of changes to the control of entry regulations.

Shortly before publishing a summary of responses to its 'balanced package of measures' proposals this week (*see p12*) the minister said that the Government's aim was to promote more competition and choice. However, she warned guests at the PSNC dinner that "we may disagree on just where we need to draw the lines".

She also acknowledged that pharmacy contractors are anxious to hear what lies ahead, but asked them to bear with the Department "a little while longer". Although an executive summary of responses to the 'balanced package of measures' proposals was published on Tuesday (*see p12*), further announcements will be made and the full report will follow later this year, alongside changes to the regulations.

The changes will be implemented in tandem with the new contractual framework, once agreed. Ms Winterton did not dwell on the aspect of funding, but said she wanted greater transparency in how services such as repeat dispensing, as well as clinical governance and IT, are funded under the new contract.

The minister urged pharmacists to be involved in the formal consultation on public health which was also published this week. In addition, a multi-professional steering group, including PSNC, has been working on a pharmaceutical public health strategy, and a draft strategy should be issued early in 2005. Before then, the DoH intends to publish a medicines management resource to support the NSFs on diabetes, renal and long-term conditions.

PSNC finds 'enormous' hole in pension fund

PSNC has identified an "enormous hole" in the final salary pension scheme it runs with the NPA and Numark.

An actuarial valuation at the end of 2003 found a hole in the fund that would require an additional £255,000 for each of the next three years, chief executive Sue Sharpe said at Monday's LPC conference. This was equivalent to an 11.5 per cent increase in levy simply to "plug the hole", she added.

Although PSNC closed the scheme to new staff members in 2000 and has made amendments to future scheme benefits, it still needs to find an extra £172,000 per year for the next three years.

"We have had to make radical cuts to our proposed expenditure for the next year to stay within the limit of 3.2 per cent," said Mrs Sharpe.

PSNC will no longer fund indemnity insurance premiums for LPC from next year. It has also cut back on external consultants and invited fewer guests to the PSNC dinner.


Sue Sharpe explains the necessary to plug the hole

Next year's conference will be held at a cheaper London venue although the dinner is likely to remain at the Queen Elizabeth II venue, while November's PSNC conference has moved to Manchester from Birmingham.

lew pharmacy strategy calls for a new contract

rmaceutical Contractors' mittee chairman Sheelin Keagny has urged the ernment to start work on a pharmacy contract for thern Ireland, following the nt pharmacy strategy. the 15th annual PCC dinner raigavad last Friday, Mr Keagney said there was a need nsider how the new strategy e delivered. "There is little t that the strategy has the potential to fulfil the ambitions of many community pharmacists. However, to use a well-worn phrase, it is inextricably linked with the need to negotiate a new contract for community pharmacy," he said.

While pharmacists want to see the strategy implemented, "we also need to emphasis the fact that my colleagues are already carrying a significant workload in relation to the 25 million prescriptions that are dispensed annually in Northern Ireland. In fact, we are seeing a year-on-year increase in prescription volumes," he said.

Referring to the Department's own survey which showed widespread public support for the services provided through pharmacy, Mr McKeagney said that the new strategy will provide pharmacists "with a valuable opportunity to extend the range of services" provided.

"The new services will, first of all, need to be proven in relation to patient benefit, and most importantly will need to be sustainable. To ensure benefit and sustainability they will need to be underpinned in a new contract which guarantees service providers the resources, both human and financial, that will be required if *Making it Better* is to be delivered."

He hoped the new contract would cover costs, investment in service provision, staff and infrastructure.

NI strategy needs clarity

ading pharmacy wholesaler called for clarification of e of the proposals in thern Ireland's pharmacy tegy.

here is uncertainty over areas as the provision of extended ices, remuneration, licines management and the nded use of IT, AAH rmaceuticals group managing director Steve Dunn said.

Making it Better highlights the importance of a contract based on service provision rather than prescription volume but there is still some "vagueness about how such a monumental step-change" is to be funded and how the different tiers of the contract will be defined, he added.

Primary care strategy expected soon

Northern Ireland is to have a primary care strategy uniting the various health professions' strategies. Director of primary care at the DHSSPS, Dr Jim Livingstone, said last week that a draft would be published shortly and a formal consultation process would commence in the spring.

Addressing the Pharmaceutical Contractors' Committee's 15th annual dinner last Friday, Dr Livingstone said he hoped to see a strategy that embraces the nursing and recently published pharmacy strategies along with others. Although GPs do not yet have a strategy, there is the new General Medical Services contract.

Since last June, Dr Livingstone has been developing the strategy to take primary care forward for the next 20 years.

"Primary care is very much driving and leading social services," he said. "As the service delivers 90 per cent of care, so we must wake the media up to the fact that most of what matters does not happen in hospital but in primary care."

Little green guide

Look out in this week's issue for the first in a series of training guides for pharmacy assistants.

Over The Counter has teamed up with Ibuleve manufacturer Diomed to create a series of four guides on commonly encountered conditions. The first module discusses common pains such as arthritis, rheumatism, sprains, strains and back pain and how to help customers recognise, diagnose and treat the symptoms associated with these complaints.

The guide also features a competition. The closing date for the competition is March 26. More copies of the guide are available from sales representatives of Ibuleve distributor Dendron.

Pharmacy Alliance plans services roll out

Pharmacy Alliance, UniChem's health improvement programme and professional services organisation, is to launch or extend a range of services this spring.

Among those that will be launched will be one allowing community pharmacists to help support patients with Parkinson's disease, one providing support in erectile dysfunction and the implementation of a new eczema programme.

In addition its diabetes project in Hillingdon PCT is to be extended, and the results of its CHD programme are being evaluated.

Pharmacy Alliance has received funding through the Department of Health's Medicines Partnership to develop the Parkinson's disease service through 18 pharmacies. Training has been developed with the CPPE and University of Bristol.

The diabetes programme has received further funding, allowing the number of participating pharmacies to be doubled. The scheme will also take in the aspect of weight management.

The eczema programme is currently being provided from 39 pharmacies and will be extended to a further 10. So far 400 patients have been enrolled and 40 have been followed up.

Over 90 per cent of the patients on the heart programme have been followed up, while the erectile dysfunction programme will launch from 50 pharmacies.

"ED is a sensitive area and patients have a lot of unmet needs," said Ziba Rajae-Dehkordi, professional service manager.

"Pharmacists can play a key role to make sure that underlying conditions are not impacting."

Fighting fund for European campaign

The Health Food Manufacturers' Association has launched a fighting fund to continue its campaign for changes in the Food Supplements Directive.

The HFMA is looking to raise £200,000 to cover legal costs of a challenge in the European Court of Justice in Luxembourg, to ensure the continued availability of the "missing nutrients" omitted from the positive list of ingredients in the Directive.

It also wants to make sure that maximum permitted levels of vitamins and minerals are based on scientific risk assessment rather than arbitrary multiples of recommended daily amounts.

A Pan-European campaign will focus on key decision-makers, MEPs, the media and on organising scientific forums.

The HFMA, National Association of Health Food Stores and Consumers for Health Choice recently spent £50,000 on a High Court ruling that the dispute could be referred to Europe. They argued that the Directive is disproportionate, unfair and restricts the free movement of goods (*C&D, February 7, p10*).

Questiontime

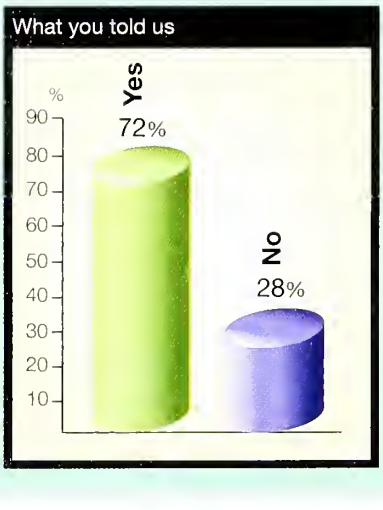
Sponsored by UniChem

Last week we asked you: "NPA chairman Hemant Patel believes all pharmacists should take an oath to uphold professional standards as clinicians. Do you agree?" You replied (see right):

This week's question: No Smoking Day is on March 10. Do you think pharmacists should do more in the campaign to ban smoking in public places?

Yes No

You can record your vote on our website: *www.dotpharmacy.com*. You have until noon on March 9 to cast your vote. We will publish the results in *C&D*, March 13.



LPS site launched

A website carrying evaluation of local pharmaceutical service pilots has been launched by Manchester University with DoH funding.

The National Evaluation of LPS Pilots website also has: information about current LPS pilots; background information; links to LPS literature; and a description of the first wave pilots.

Project manager Juliette Kendall said: "The evaluation examines issues such as how LPS is enhancing community pharmacy services, the pros and cons of LPS for patients, professionals and the NHS, whether LPS results in improved access to care and whether the pilots result in improved quality of care for local communities."

PIA is preferred

The representative body for pharmacy technicians has chosen The Pharmacy Insurance Agency as the preferred supplier of legal defence and professional indemnity insurance cover for its members.

The Association of Pharmacy Technicians said it was currently "working on the final details" and that it would launch a range of "significantly discounted" packages at its annual conference in Northern Ireland in April.

ETP live from Jan 05

Roll out of the electronic transfer of prescriptions system can be expected from January 2005, the health minister has announced.

Work on ETP deployment is now concentrating on community pharmacy, said Rosie Winterton, and on how it can be networked into the system. In addition, investigations into how pharmacy computer systems can be upgraded to meet the technical specification needed to link to N3.

Wales consults on oxygen services

The Welsh Assembly is inviting comments on the future provision of domiciliary oxygen services.

The consultation letter outlines the DoH-proposed model for England, but says that a different contract for Wales could be produced. In addition to proposing five options for the provision of long term oxygen therapy, the document suggests retaining the community pharmacy role in short-burst oxygen therapy provision.

Community Pharmacy Wales chief executive Peter Haydn Jones said that it was planning to respond to the consultation before the March 26 deadline.

WIN a luxury break for two at a Champneys Healthfarm

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HEALTH RESORTS

www.champneys.com

Enter the Kool 'n' Soothe & Cura-Heat Display Competition 2004!!!

t's very simple - all you have to do is take your own photo of your Kool 'n' Soothe & Cura-Heat displays using the "Special Point of Sale Kit" and you could snap up a luxury break at a Champneys Healthfarm.

To enter cut out the entry form below, place in an envelope making sure to attach a stamp, or register online at **www.koolnsoothe.com.** You will then be sent a "Special Point of Sale Kit" which has everything you need to create a photogenic and eyecatching display meaning a great display for your customers and an even greater profit for you.

Entries to be received by 31st March 2004. Winners will be announced in the June 26th edition of the Chemist & Druggist and online at www.koolnsoothe.com

Cut out and send to Kobayashi Healthcare Europe Limited, Office 264 B3, Chiswick Park, 566 Chiswick High Road, London, W4 5YA

Pharmacy name:

Your name / entry person for prize:

Pharmacy address:

Postcode:

Pharmacy Telephone number:

Competition rules:
The successful competitor (s) will be determined in accordance with these rules and the procedures set out in Kobayashi Healthcare Europe, which are deemed to be incorporated in these rules. The promotion is only open to registered pharmacies in the UK, Scotland & Ireland that stock Kool 'n' Soothe and/ or Cura-Heat. The prize(s) as set and no competitor can elect an alternative to it /them. No cash alternatives will be entered into. No competitor can win more than one prize in the promotion. Only one entry will be accepted per person. All entries must include the competitor's name and address and contact details as directed. Publicity may be given to each winner. Kobayashi Healthcare Europe reserves the right to feature/ use names and photographs in future publicity by entering this promotion you are agreeing to this. No responsibility can be taken for entries damaged, lost or mislaid before or after delivery. Failure of an entry to be delivered by the date or in the manner specified will make the entry invalid. Proof of posting will not be accepted as proof of delivery. No correspondence will be entered into. Employees and agents of Kobayashi Healthcare Europe or of any company associated with the promotion are not eligible to take part, nor are their relatives or members of their families or households. The determination and decision of Kobayashi Healthcare Europe shall be final. Kobayashi Healthcare Europe reserves the right to disqualify any entry or competitor, or nominee, add to or waive the rules. Kobayashi Healthcare Europe reserves the right to substitute prizes of equal or greater value. The registration closing date for entry to the competition is 31st March 2004. A list of winners will be available after the closing date in the June 26th issue of Chemist & Druggist and online at www.koolnsoothe.com.

Kool 'n' Soothe Migraine
PIP code: 288-2793
Immediate cooling relief for Migraine & Severe Headache

Kool 'n' Soothe for Children
PIP code: 280-7071
Immediate cooling relief for hot & feverish children

Cura-Heat
PIP code: 299-2048
12 hour warming relief for back, shoulder & neck pain

J&J buys Merck interest in European joint venture

by Sasa Janković
sjankovic@cmpinformation.com

Johnson & Johnson has agreed to buy Merck's 50 per cent stake in its European non-prescription pharmaceuticals joint venture Johnson & Johnson. MSD Europe for an undisclosed sum.

Once completed, the acquisition will give Johnson & Johnson 100 per cent ownership of the business.

Johnson & Johnson Merck Consumer Pharmaceuticals Co, a 50/50 joint venture between Johnson & Johnson and Merck in the US and Canada, is unaffected.

The new entity will continue to expand the current Merck over the counter switch products marketed by the joint venture and expanding operations to other European countries.

As part of this, the companies anticipate the launch of an OTC version of Merck's prescription cholesterol-lowering drug Zocor (simvastatin) in the UK in mid-2004, pending regulatory approval.

"Through this acquisition, we will be able to establish a single, pan-European consumer pharmaceutical company that will be well-positioned to benefit from the changing European market for non-prescription pharmaceuticals," said Brian Perkins, worldwide chairman, Consumer Pharmaceutical and Nutritionals, Johnson & Johnson.

It represented "an evolution of our successful partnership with Merck in Europe", he added.

Johnson & Johnson. MSD Europe – which includes Laboratoires Martin-Johnson & Johnson-MSD SAS in France, Woelm Pharma GmbH & Co in Germany, Centra Medicamenta Srl in Italy, Abello Farmacia SL in Spain, and Johnson & Johnson. MSD Consumer Pharmaceuticals in the UK – will become a wholly owned subsidiary of Johnson & Johnson upon completion of the acquisition.

The transaction is subject to a competition review by the European Commission.

Vantage offers a spring Mini adventure

One lucky Vantage Pharmacy customer will drive away in a brand new BMW Mini courtesy of AAH Pharmaceuticals, as part of a spring promotion.

All Vantage Refresh Pharmacies are being offered the chance to display leaflets advertising the free to enter competition.

Leaflets contain an entry form and details of different promotions running in Vantage pharmacies throughout the spring. The leaflets are customised with the pharmacy's name, address, opening times and details of any additional services they offer.

The first 200 customers to enter in each store also qualify for a free spring health guide with 16 pages of advice on subjects such as hay fever, oral health, diabetes and family planning.

MHRA publishes naming guidelines

The MHRA has published guidelines on naming products in umbrella sectors.

As a rule, MHRA says it "encourages applicants to develop new product names without umbrella segments for each product". However, it "will consider on its merits each application for a product name including an umbrella segment".

The agency states that its principal considerations are to ensure that medicines are taken safely and correctly, that a proposed name will not give rise to safety or efficacy concerns, and that the name complies with legislative requirements.

Its licensing authority may reject any name it considers may cause confusion, is misleading or is otherwise unsafe (*see also p13*).

For more information:

www.mhra.gov.uk

SDEA launches legal helpline

The Shop and Display Equipment Association has launched a 24-hour legal advice service for members. A team of solicitors, barrister, legal executives, employment, personnel, health and safety and taxation experts are on hand to answer members' questions 365 days a year. Contact Lawrence Cutler at SDEA on 01883 348911 for details.

Double Deals

Rowlands has introduced a new theme to its promotional gondola ends. Double Deals gives the consumer a saving incentive when purchasing two products.

The offers cover a cross-section of OTC toiletry lines and is backed by merchandising materials.

"Primarily, the function of this promotion is to increase customer awareness of the Rowlands value for money proposition and to build customer loyalty," said Mike Johnson, Rowlands' marketing manager.

Yamanouchi and Fujisawa merge

Yamanouchi has agreed to buy fellow Japanese firm Fujisawa for around £4.1 billion in an all-share deal that will create Japan's largest pharmaceutical company. The merged company will rank 17th in the global pharmaceutical market.

Activa moves for growth

Activa Healthcare has moved to larger, purpose built premises in Burton on Trent.

Its new offices at 1 Lancaster Park, Newborough Road, Needwood, include a compression therapy training room for health professionals, bigger warehousing and a new IT system.

Activa can be contacted on 08450 606707.

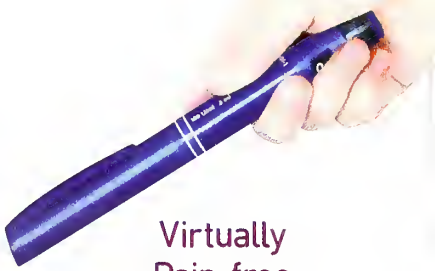
Brunel to distribute Efamol

Brunel Healthcare has been appointed to handle distribution of the Efamol range in the UK. The move follows the recent acquisition of Efamol Ltd, including the brands Efalex and Efamol, by a Yorkshire management team led by Bob Jackson, Peter Clough and Norma Jackson.

Efamol is a range of nutritional supplements based on Essential Fatty Acids and was formerly owned by Nutricia.

For people using insulin...

Large modern display



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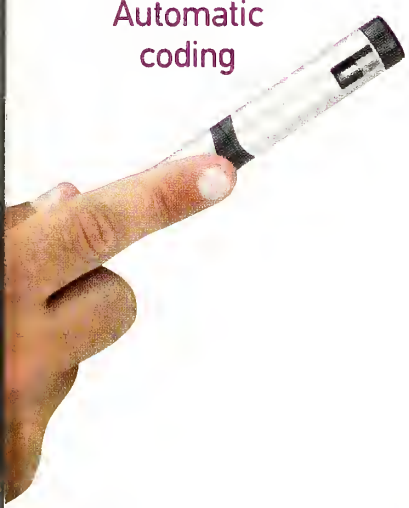

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Pharmacist warns others to check AAH invoices

by Sasa Janković
sjankovic@cmpinformation.com

A Middlesex pharmacist has warned others to check their invoices from AAH Pharmaceuticals carefully after products she ordered were listed out of stock and replaced with more expensive items.

On another occasion the product she ordered, which was the cheapest on the list, was out of stock and she was told that AAH would substitute it with another, more expensive brand. When the order arrived the original product had been supplied, but invoiced at the more expensive price.

The pharmacist warns that those with a busy dispensary may not even notice that this is happening, although she adds that AAH will correct the matter if contacted. However, this can take a while as it requires the pharmacy to return the stock and request a credit note.

An AAH spokesman defended its so-called 'chaining system', saying: "Should the original product ordered not be in stock, AAH customers have the option of getting a replacement via AAH's chaining system. This means the customer will be supplied an alternative generic product to ensure they have the stock they need, when they need it.

"AAH keeps back-up stocks in order to meet this customer demand, but these products will usually be towards the higher end of the price scale. This is because they will have been sourced at a different time and from different suppliers to the out of stock product, thus costing AAH more to purchase and store. AAH has to pass these extra costs on to its customers.

"On some infrequent occasions the item supplied from the back-up stock will be the same as the original item ordered, but at a higher price due to the factors outlined above.

"If a customer is dissatisfied with any product delivered, AAH operates a three-day returns policy which ensures the product can be returned and the customer can be credited, or the customer can request that products are not chained in an out of stock situation."

For more information:
AAH Pharmaceuticals
Tel: 024 7643 2000

UniChem best practice near completion

UniChem is on course to complete a £20 million best practice roll out at its UK distribution centres.

The programme has included upgrading the dispatch and scanning system at its Livingstone branch, a warehouse rebuild at Croydon and a new dispatch system and warehouse in Preston.

UniChem's Hinckley distribution centre acted as the test site for maintaining service levels while implementing best practice.

David Wignall, general manager UK projects, said: "The aim was for the best possible layout in each warehouse to provide the best possible service for customers."

Axis aims for pivotal healthcare supplies

A new healthcare products supplier has launched this week, claiming to meet core customer service values such as quality and price, plus best advice.

Axis Medicare has been set up by Trevor Leese, its commercial manager, who said: "This is a very exciting challenge for me. I have worked very closely for many years with major pharmacy groups and independent pharmacies along with general practitioners, primary care trusts and organisations to help them improve their profitability on a wide range of products. I think Axis can make a substantial impact in this area."

Based in Barton-under-Needwood in Staffordshire, and backed by Kent Pharmaceuticals, the Axis product range will initially cover wound care in addition to catheters, leg bags, night drainage bags, and sheaths. It will shortly extend this to include stoma appliances and consumables.

Mr Leese said: "The Axis philosophy is to offer alternative supplies of products best suited to formulary needs at cost-effective prices.

For more information:
www.axismedicare.com.

Only one nicotine patch **protects** customers from unnecessary sleep disturbance.

Because Nicorette 16 hour Patch is the only patch specifically designed to mimic your customers' regular smoking pattern, it avoids the nocturnal nicotine dosing often associated with sleep disturbance.[1,4]

Nicorette 16 hour Patch is the only one not shown to increase levels of sleep disturbance over and above placebo levels.[2-6]

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nicotine

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Choice and competition test may not improve control of entry rules

Government advisors have questioned whether the new test for choice and competition set out in the Government's control of entry proposals will enhance the current contract application.

In the summary of responses to the consultation on the Government's 'balanced package of measures', published on Tuesday, they also say that some of the proposed exempt application categories need a tighter definition, and should always be considered only as exceptions to the entry rules.

The Advisory Group on the Reform of the NHS (Pharmaceutical Services) Regulations 1992 has, however, given the green light to the first test, covering the provision of minimum, 'essential' tier services as outlined within the new pharmacy contract. In this context, the group recommends the criteria currently being developed by Sheffield PCTs for use in their NHS LIFT assessments.

On the second key question of choice and competition, though, advisors warn that these tests could engender a level of uncertainty that could result in a judicial review.

While a test for market share would be more certain, this could constrain rather than enhance competition, they say. Advisors suggest that local pharmaceutical services should be promoted as one available interim mechanism to enhance consumer choice.

On the proposed exemption for premises offering over 15,000 square metres gross lettable floor space, however, the group proposes the clearer definition: "A retail development with gross lettable floorspace in excess of 15,000sq m, developed as a single physical entity."

Vision responses question place of POM to P

Pharmacists have a definite role in self-care and providing health and lifestyle advice, but not necessarily with more non-prescription medicines, the summary of consultation responses to the *Vision for Pharmacy* in the new NHS strategy document reveals.

Around nine out of 10 of the 145 responses received by the Government support the role of pharmacists in self-care, and there is general welcome for developing pharmacy's contribution in public health.

However, less than 10 per cent of respondents wanted to comment on proposals to expand the range of medicines pharmacies can supply without a prescription, and those that did voiced concern about achieving the right balance between patient safety and patient choice.

Patient benefit is also flagged up as an issue.

There was more response to the new pharmacy contract, though, with nearly half of all respondents considering it fundamental to achieving the *Vision*.

Two thirds of respondents support the chief pharmaceutical officer's 10 key roles for pharmacy and about one third of respondents consider supplementary and independent prescribing by pharmacists key to improving patient access and making good use of pharmacists' clinical skills.

Adequate funding will be fundamental to achieving the *Vision*'s aims, almost all respondents agree.

The responses also highlight skill mix and staff career development issues.

PAGB PERSPECTIVE

What's in a name?

Think of what the brand name means to the patient and always remind them to read the label, says PAGB director Sheila Kelly

Shakespeare may have thought that a rose by any name would smell as sweet but that's not how consumers view the names of OTC medicines. Anyone browsing through the medicines on self-selection in pharmacies or grocery outlets can see that the range of medicines sold under a single brand name is growing. Evidence shows that brand recognition can be the key to the successful launch of new OTC products.

Health professionals are often surprised by this. Mention a brand name to a pharmacist, and what springs to their mind is an ingredient with all its associated pharmacology and posology, but it's not like that for a customer.

The familiarity of a well-known brand name brings to mind immediately the illness the product treats, the expectation of relief and the trust that the product will not do them harm. All of these factors are essential if people are to be persuaded to try a new product rather than reach for their usual product, which they do in more than 80 per cent of cases.

Marketing models now show that using an existing brand for a new product increases its chance of success by 30 per cent. As major pharmacy and grocery retailers take an increasingly commercial approach to the range of products they stock, this can mean the difference between the product being stocked in the first place. However, in taking this route, the key issue of consumer safety can't be ignored, especially if the brand name is being used across a number of products with different active ingredients.

Companies have to get all brand names approved before marketing, along with the rest of the product details. It is helpful that the Medicines and Healthcare products Regulatory Agency has now produced guidelines for manufacturers using brand names in this way.

The new guidelines bring a systematic approach to evaluating the safety of the proposals. Every aspect of the use of the product will be taken into account, including the therapeutic rationale for the proposal, the dose, duration of use, contraindications, interaction profile, side effects and any special warnings.

On top of that, the pack design, colours and layouts are checked to ensure that any significant differences between the different products in a range are signposted. This is a process the industry has been following anyway, but the guideline makes it more transparent and explains the basis of the MHRA approvals. So what more needs to be done?

The ingredients in OTC medicines have to have a good overall safety profile and fortunately, in most cases, switching from one ingredient to another won't have any adverse consequences, but it would be good practice to encourage people to check the labels, even if they are familiar with the product. Over the next few years new EU requirements for medicine labels will increase the prominence of the names of active ingredients.

All OTC medicine advertisements already include a reminder to read the label, but people using familiar products may not check the label every time they take the product. Pharmacy staff doing the WWHAM questions check whether the customer has used the product before and then stop the questioning. It would be a real contribution to public health if they went on to remind the customer to read the label.

Comment from the Editor

Last week's question was: NPA chairman Hemant Patel believes all pharmacists should take an oath to uphold professional standards as clinicians. Do you agree?

"Why not? It wouldn't do any harm and may increase our professional standing"

David Fife, Bristol

"I think it's superfluous. We would need definition of which professional standards are being referred to and what a 'clinician' is in this sense"

Elisabeth Hopkins, Middlesex

"I think so. We have a duty to be professional with patients. I think it would improve the profession's image"

Mark Bone, Paisley

Guests at the PSNC dinner on Monday may have been surprised at the warmth of the reception extended to health minister Rosie Winterton. Despite PSNC chairman Barry Andrews's comments about the inadequacies of the recent pay imposition, the minister managed to charm some of the non-pharmacist guests who may not have realised just how much the pay 'deal' hurts.

Reaction from the pharmacists was more critical – yes, the minister spoke effusively about how good pharmacists and community pharmacies are, but that's what most of the public thinks anyway and is what a variety of ministers have been saying for many years. It would have been nice to hear something more substantial.

There was little that pharmacists could take back to their pharmacies and look forward to implementing. Instead, more consultations were announced while the consolidated responses to others were published. Confirmation of certain delays was not unexpected but the minister's coded language anticipating potential hostility to the changes the Government will make to the control of entry regulations will have people wondering just what the purpose of these profligate consultation exercises actually are.

Another concern is just what 'plan B' is. The new contract depends on contractors' approval. While everyone agrees that the framework is what pharmacists want to be doing, pharmacists have yet to be balloted on the funding structure and could reject it. Presumably, this can be discussed when PSNC starts its second series of contract roadshows. But what if the answer is that there is no alternative? Will it be an imposition by default?

The minister managed to charm some of the non-pharmacist guests

Yourviews

Geoff Mackay of AAH welcomes Scotland's progress on the IT front

A valuable lesson to learn

I read that a recent report on Scotland's IT pharmacy project criticised those in charge of having a "slow" and sometimes "piecemeal" IT strategy.

In many ways, Scotland has got it right. Those in charge of its healthcare reform have actively sought out the niche providers who have the intimate knowledge on delivering pharmacy systems. This is unlike the rest of the UK which is only just starting to listen to the many voices that will help deliver the *Vision*.

While I agree with many of the recommendations made by the audit committee's report, I would advise the Scottish Executive to exercise a degree of caution in going from pilot schemes to a national rollout of IT systems. There are clearly still a number of issues to iron out and, when it does move to a national programme, no doubt more will arise.

In many ways Scotland is ahead with its national IT programme. If implemented properly it could be a valuable example. If rushed, there is a danger of throwing the baby out with the bathwater, losing the value and intelligence gleaned from the pilot stages.

In England it is hoped all pharmacies will have access to NHS Net, including the ability to access ETP and ICR by the end of 2005. Looking at the progress that has been made to date, this deadline is very ambitious.

Delivering technology is only half the battle. It is no good making available the necessary tools and equipment to pharmacists without training and support.

While the Government's *Vision for Pharmacy* is admirable, it does not contain the level of detail that shows how the vision will be delivered. It will be down to niche pharmacy providers and wholesalers to provide this much-needed support and training as they already deliver systems into pharmacy and have worked hard to gain trust and respect in the sector.

Northern Ireland NOTEBOOK

TOPICAL REFLECTIONS

Another case for being able to amend scripts

Last autumn Aventis decided unilaterally that instead of the single form of capsules for generic ramipril there would be tablets as well. At a stroke it doubled my stockholding and increased the eventual generic price, as it is more expensive to produce both tablets and capsules.

From my perspective it is an idiotic scenario, justified by a dubious explanation from Aventis, but one that is also out of the control of the NHS and will ultimately cost it a lot of money. On the other hand, some draconian rules are applied in the *Drug Tariff*, which appear to defy both therapeutic logic and financial probity.

I regularly receive FP10 prescriptions from dentists for erythromycin capsules that have to be returned for amendment or refused, and then the patient is sent back for a new prescription. Whatever the reason, I am made out to be the "job's worth" culprit who is incapable of applying professional flexibility for the patient's benefit.

Dentists can prescribe whatever form of a drug they like when issuing a private prescription, but not under the NHS. It is rare these days that all forms of drugs are not available generically, and this particularly applies to the limited range of drugs that dentists are allowed to prescribe under the NHS.

It would make all our lives much simpler if this archaic distinction between forms is now removed from the tariff and both dentist and pharmacist allowed the discretion required to efficiently treat the patient.

Drug waste and the need for communication

As responsibility for medication management devolves away from GPs, I am becoming increasingly aware of the problems of effective management.

Recently I had returned to me six months' supply of enalapril by the GP on behalf of an elderly patient who had had a domiciliary visit. Not only was the patient not taking the drugs as prescribed but on examination there was also nothing wrong with her blood pressure.

I cannot criticise the GP because it must be impossible to closely monitor patients, particularly if they are house bound. The wastage eventually came to light and has now been rectified, but I now regularly take responsibility for ordering repeat prescriptions for a number of house-bound patients, and I have so far failed to solve the problem of proper monitoring.

The ultimate responsibility for determining whether a repeat drug is required is with the patient, and I can only monitor unusual usage patterns through examining their cumulative drug history. I can also encourage the carer (whether friend, relative or professional) to check and inform me if drugs are not being taken correctly or too many are being ordered. Between all of us the problem can be reduced but never eliminated.

Every patient presents with a different problem, and each requires an individual solution. In the past I have criticised GPs for poor management but now I am beginning to understand their difficulties. Logically, long-term medication management should be a pharmacy-based service, but it will only be more effective if there is active co-operation between pharmacist, surgery and patient.

Reverting to type

Out of last week's heavy *C&D* fell a rather handsome booklet from Pfizer. *The Vision* seems to be its attempt to define changing patient patterns and highlight ways of exploiting – in the most worthy sense – the opportunities brought through knowledge of your customers.

It is generous too, for Pfizer to be willing to share its findings, so that the industry as a whole may benefit. But which of the four basic types of consumer do you fall into? Could this be a case of "do as I say, not as I do" when I look at the contents of my own medicine cabinet at home?

Making it Better ... but will it?

This week I thought of Oscar Wilde's quip: "Be careful what you wish for: you might just get it."

My thoughts of the cynical Mr Wilde were prompted when reading that something I have wished for for many years had finally arrived (*C&D, February 14, p4*). *Making it Better: the Strategy for Pharmacy in the Community* was launched with encouraging ministerial comment. But with has more portfolios than a pension plan (agriculture, health and social service, and education), I was reserved on what she said.

I was rather more impressed by our chief pharmacist and his comments. Full marks to him and his staff for delivering the strategy. The very existence of *Making it Better* allows government money to be spent on community pharmacy. These issues are now policy and where funds are available they may be applied to

The very existence of *Making it Better* allows government money to be spent on community pharmacy

improving our profession. Along the lines of the strategy, of course.

On a first reading there are no huge surprises. Repeat dispensing is a must and tomorrow if possible please. I am impressed with a promise to make funds available to improve my premises.

But there are elements that I'm not sure about, public health for one. Apart from smoking cessation services I'm not sure what the other parts are.

And then there's the more surreal aspects of the strategy. The quality issues are rather confusing – are we not the most regulated profession on the planet?

But all in all I welcome the strategy. Oscar Wilde's words are much too cynical in this case.

Written by a community pharmacist in Northern Ireland

Glucosamine

Your body's joints undergo many trials throughout their lifetime. But there is an increasing volume of clinical evidence suggesting that glucosamine can be helpful in healing joint injuries and relieving degenerative conditions such as arthritis

Glucosamine is an amino sugar that is produced naturally by the body from glucose and glutamine. It is a nutrient specific to the connective tissue – it is found particularly in cartilage, tendons and ligaments.

It has been described as the "cement of the connective tissues" because one of its essential functions is to stimulate the manufacture of cartilage components called glycosaminoglycans (GAGS) and proteoglycans (PGs). GAGs form the bulk of most cartilage tissue.

There has been debate over the value of using glucosamine in treating osteoarthritis, but the evidence in its favour has been gathering weight. Giving its comments on a systematic review conducted by Richy et al (*Archives of Internal Medicine 2003 163:1514-1522*), Bandolier says that the clinical bottom line is that as many as one in five patients with knee arthritis will benefit from using oral glucosamine at 1,500mg daily.

Fifteen studies were included in the review, with data on 1,775 patients (1,020 glucosamine and 755 chondroitin). Quality scores were high, notes Bandolier. Glucosamine doses were mostly 1,500mg daily. Trial duration was 6-8 weeks to three years. Chondroitin doses were 800mg to 2,000mg daily in trials of three months to one year.

Glucosamine significantly reduced joint space narrowing by 2.7mm over three years compared with placebo. Given in combination, glucosamine and chondroitin improved continuous outcomes such as pain and mobility. There was no difference between treatment and placebo for adverse effects.

This reinforces conclusions reached in a Cochrane review in 2001 (*T E Towheed et al. Cochrane Library Issue 1, 2001*) and a meta-analysis by T E McAlindon et al (*JAMA 2000 283: 1469-1473*).

How it works...

The precise mechanism of action of glucosamine when taken as a supplement is unclear. There is a significant decrease in the glucosamine content of osteoarthritic cartilage, which in turn leads to a fall in the amount of chondroitin sulphate. Glucosamine takes part in the synthesis of both chondroitin sulphate and hyaluronic acid, and these two compounds are also both depleted in osteoarthritis.

Three possible mechanisms have been put forward:

- Inhibition of cartilage breakdown.
- Promotion of cartilage repair.
- An anti-inflammatory effect.

Elastase is an enzyme which has an important role in breaking down articular cartilage in arthritis sufferers.

Why chondroitin ?

Glucosamine is frequently combined with chondroitin in supplements. What is the rationale?

To help answer that question, let's look at the structure of the knee joint. The ends of the femur and tibia meet at the knee and are covered with a material called hyaline cartilage. This cartilage contains cells called chondrocytes which are surrounded by a tough yet flexible 'matrix'.

The matrix includes collagen fibres, elastic fibres to promote flexibility, and proteoglycans. These proteoglycans have a protein trunk to which are attached branches of sulphated mucopolysaccharides (complex carbohydrates which bind with water to form a jelly-like substance). One of the most important mucopolysaccharides in the human body is chondroitin sulphate.

Chondroitin sulphate has a highly electronegative structure with a powerful capacity to attract and retain water molecules. The resulting ample presence of water within chondroitin sulphate-rich cartilage means that it is elastic, yet highly resistant to friction and impact forces. It's one reason why cartilage is so good at protecting bony tissue from damage during movement.

Bones can not grind away at each other when they are capped properly with cartilage, and the cartilage itself is usually not damaged because of its flexibility and resiliency.

In osteoarthritis the cartilage matrix is disturbed, and the molecules of chondroitin sulphate begin to break down, causing the cartilage to lose its water-retaining properties and protective function.

The attraction of chrondoitin supplementation is that it might replace what is being lost in the joints as part of the disease process. There is evidence in clinical trials involving small numbers of osteoarthritic patients that some relief in symptoms is seen after 1,200mg has been taken for 30 days or more (*J. Rheum 23(8):1385-1391, 1996*).

N-acetylglucosamine inhibits the enzyme in a dose-dependent way, and so may be a factor in preventing cartilage breakdown.

D-glucosamine, the active principle of glucosamine salts, is a small molecule that easily diffuses through biological membranes. It has a high affinity for cartilaginous tissue and is incorporated into proteoglycan molecules. It is also the preferred building block for the synthesis of GAGs.

Commercially glucosamine comes in three basic forms:

- N-acetylglucosamine is selectively taken up by the liver, so there may be less available to repair cartilage.
- Glucosamine sulphate breaks down in the presence of air and water, so sodium or potassium chloride is often used as a stabiliser. It may account for a third of the total weight of the compound. The sulphate grouping accounts for a further 20 per cent, so some products may only contain half their weight of the active.
- Glucosamine hydrochloride is claimed to contain 83 per cent active principle and to be more stable.

Health Perception passes the glucosamine test

Always read the label before you buy a glucosamine product.

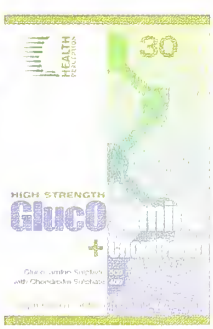
Health Perception's is:

- The original glucosamine
- Glucosamine and chondroitin – both from marine source
- Has undergone hospital trials
- Pharmaceutical grade quality
- Offers the widest choice – there is something there for everyone, which means that the consumer can chose from a tablet, gel, gel patch, effervescent or the NEW liquid format.

Whichever you choose, you can be sure of the strength, quality and concentration of the product.

Joint Solutions from Health Perception

Glucosamine Sulphate Tablets
Age, injury and disease all deplete the body's level of glucosamine. By taking a glucosamine sulphate supplement you are helping to relieve back pain, arthritis and joint stress, and helping to speed up the healing process of joint injuries.



Glucosamine & Chondroitin Tablets
Chondroitin sulphate exists in the body in the form of chains of repeating sugars, and is known as the "liquid magnet". This is because chondroitin sulphate helps to attract fluid into the joint. Health Perception's glucosamine and chondroitin supplement is ideal for people who already have an advanced type of pain or discomfort.

Glucosamax uses a unique new technology which compresses all the glucosamine into an easy-to-swallow tablet, providing 1,500mg glucosamine sulphate, the amount used in scientific trials. So just ONE tablet daily could provide nutritional support for the joints throughout the day.

NightOsamine is a unique capsule that combines cod liver oil, a nutrient known for its role in helping maintain supple joints, along with hops and lemon balm extracts. So two capsules helps provide your joints with nutritional support whilst they are at rest at the end of the day.

BackOsamine has the added benefit of turmeric and bromelian. Turmeric is well known for its natural anti-inflammatory properties, without the side effects. Bromelian has been shown in over 400 scientific papers to improve mobility, reduce inflammation and joint swelling. Bromelian is believed to also enhance the absorption of glucosamine.

GlucOsamine Gel and GlucOsamine Gel Patch
Topical application of glucosamine is an ideal solution towards "localising an area of pain and discomfort". N-acetyl glucosamine is a specialist form of glucosamine that provides a sustained release of gel over time into the skin. Health Perception's glucosamine gel was developed at the School of Pharmacy & Biomolecular Sciences, University of Brighton.

New Joint-Flex liquids

GlucOsamine and GlucOsamine and Chondroitin for those who would prefer a liquid format of glucosamine and glucosamine and chondroitin. JOINT-FLEX liquids are a delicious strawberry flavour and are fast acting! Glucosamine hydrochloride has been used in the drink due to its excellent stability and purity in a liquid format. Liquids are absorbed quickly, so improving the effectiveness of the active ingredients (90% of liquids are absorbed almost immediately).

Gary Paragon reports on Monday's conference

NEL refusal to pay levy is 'immoral'

North East London LPC's refusal to pay its levy to PSNC for the past two years is "immoral" as it means all the other LPC's have been subsidising them, Brian Wilkins, Salford LPC warned at PSNC's annual LPC conference on Monday.

However, chairman Barry Andrews said PSNC was in "delicate" negotiations with the LPC, which would be resolved within a week. He said PSNC would take steps to ensure "this can't happen again".

Divyesh Shah, Leicester LPC, called for PSNC to issue a standard cost-of-delivery template. He said Leicester's PCTs were commissioning services without consulting the LPC and as a result were "paying peanuts".

Chief executive Sue Sharpe suggested if PSNC published a template, the OFT could construe it as anti-competitive. She added that under the new contract locally commissioned services will have national frameworks and national prices, so that LPCs could tell PCTs: "This is the service and this is how much it will cost you."

Lambeth, Southwark & Lewisham LPC's Div Tanna asked for PSNC's position regarding the DoH's consultation on oxygen services. Financial executive Godfrey Horridge said PSNC was trying to retain oxygen business for contractors but the DoH had clearly indicated it wanted to open the service to other providers.

Hertfordshire's Graham Phillips said it was difficult to look forward after the recent pay imposition for pharmacy. Mr Andrews replied that it was "inevitable the Government would try and get us on the cheap" but added it was important to build an evidential base and have "well-informed" contractors for the contract ballots.

Bexley, Bromley & Greenwich's Gordon Davie highlighted the fact that GPs would no longer be required to provide out-of-hours services from next month.

NHS services head Alastair Buxton said PSNC was negotiating with the DoH but because of the diversity of OOHs services there may not be a single model that fits everybody. He said the NPA and PSNC would jointly launch an information pack on OOHs soon.

North Derbyshire's Gary Myers highlighted the move by some PCTs to use branded generics. How can LPCs vote for new funding arrangements in the absence of a mechanism to prevent 'cherry-picking' he asked?

PSNC was resisting the DoH's wish to change the *Drug Tariff*, as PSNC wanted to keep existing profit sources until new funding was in place, Mrs Sharpe said.

Worcestershire's Nitin Sodha called for PSNC and the NPA to merge. Mr Andrews replied that now was the wrong time to merge, as it was "helpful to have two voices expressing different shades of the same opinion".

Script switching and skill mix top LPC debate

Prescription switching, skill mix and corporate governance were the key topics for debate at the conference. Rather than dwell on last month's pay imposition, delegates accepted 10 of the 14 motions, often with little or no debate.

Wiltshire LPC's Alison Kidner called on PSNC to ensure the PPA returned all prescriptions switched from exempt to paid categories. She was concerned over lost revenue and said pharmacists received no feedback from the PPA.

PSNC information services head Lindsay McClure said the PPA had changed its 'keying-in' process, resulting in a 7 to 9 per cent drop in the number of switched prescriptions. She said 78 per cent of switched prescriptions were 'miss-sorts' and no penalty was incurred. She also highlighted the concession where the PPA accepted computer-generated ages on prescriptions. The motion was carried.

Birmingham LPC proposed that pharmacists should be given greater discretion for decision-making in the dispensing process.

"SOPs will enable clarification on when and for what reasons there must be involvement of the pharmacist during dispensing," the LPC argued.

The new contract will place time demands on pharmacists and it must be clear that pharmacists can choose when they delegate, Birmingham's John Carr argued.

Hertfordshire's Graham Phillips opposed the motion on the grounds that it was geared to pharmacists being away from the pharmacy, which would be unacceptable to patients. This was "dangerous ground", he argued, because if technicians run pharmacies, the government will only pay a technician's salary. In voting against the motion the conference agreed that pharmacists should always be present when pharmacies are open.

Sefton LPC proposed that LPC members should not be PCT salaried employees as "such joint office is incompatible with transparency." It added that PSNC discussion materials regarding contractual results would no longer be confidential. Sefton's Alan Woodcock asked if an LPC member was also paid by the PCT: "Which master would he serve?"

Essex LPC's Simon Moul opposed the motion as it discouraged pharmacists from getting involved in PCT activities such as clinical governance and medicines management leads.

Norfolk's Norman Dean said the motion questioned pharmacists' integrity and sent the wrong message to PCTs.

Wakefield's Phil Bratley, who is both an LPC secretary and pharmaceutical adviser, said his joint roles allowed an understanding of both sides' stance. He highlighted how his LPC background had helped to stop a PCT initiative to use branded generics.

Other motions which were passed included: a clear resourced strategy to allow every pharmacy to offer chronic disease management should be available within six months (Lambeth, Southwark & Lewisham); PSNC should negotiate for ring-fenced money to develop supplementary prescribing (Berkshire); pharmacists should be allowed to claim broken bulk on dressings (Manchester LPC); the implementation of patient pack prescribing and dispensing (Sandwell); and a plan should be developed to initiate NHS funded training for pharmacy staff (Croydon).

Focus on future, says Andrews

Pharmacy contractors' sights were focused firmly on the opportunities of the new contract at the annual LPC conference in London on Monday.

"It offers community pharmacy a unique opportunity. How we respond is up to us," PSNC chairman Barry Andrews said. "We can focus on the inequities of the present contract ... and we can persuade ourselves that nothing will change. That would be a waste of energy. Worse, it may be a self-fulfilling prophecy."

Despite no new details about the structure of funding of the contract, Mr Andrews was upbeat. "We will all be stretched in the year ahead. It will be a decisive year. It could mark the most significant move forward for community pharmacy in all our professional lives."

Making only passing reference to the pay imposition announced a fortnight ago, Mr Andrews outlined PSNC's goals for 2004. These mainly revolve around the new contract (*see panel*).

Last year saw a "quite remarkable change in the profile of community pharmacy", said Mr Andrews. Pharmacy is now "very clearly visible" to NHS policymakers, whereas it was "off the radar" at the start of 2003.

The lobby against the OFT's proposal to abolish control of entry was successful in persuading the Government to reject total deregulation for the time being.

"PSNC is not happy with the compromise proposals. They make no sense. We will be working to limit their impact as much as we can. And it is clear the OFT has not gone away," said Mr Andrews.

But the campaign did make the Government understand that the public likes and respects community pharmacies, he continued. "We made them realise that while they have ignored and undervalued us, many patients have a strong commitment to their local pharmacy and value the services."

PSNC goals for 2004

- Securing best possible funding arrangements for the new contract. Roadshows where contractors will be able to examine the small print are planned for late April/May.
- Provide rewards for advanced service providers and time for introduction of advanced services.
- Include retained purchase profits in the system.
- Establish comprehensive costings for the contract.
- Ensure *Drug Tariff* simplification does not disadvantage contractors.
- Develop tools to prepare the evidence base for current and future negotiations.
- Ensure paperwork and payment systems for new contract are simple and transparent.
- Ensure manageable transition arrangements from old to new contract.
- Ensure that community pharmacy is an integral part of the NHS IT agenda.
- Provide material for contractors to evaluate financial effects of new contract.
- Develop PCOs' understanding of community pharmacy, and raise LPCs' profile.

Ple@se e-mail your views to chemdrug@cmpinformation.com

Why the Society should withdraw the Charter petition

We will resist the urge, tempting though it is, to trade personal insults with Peter Curphey (*C&D, Feb 28, p16*) and concentrate instead on any matters of substance that lie buried beneath the weight of his diatribe.

As far as we can tell he was trying to say something about council/cabinet responsibility, something about democracy and something about the Charter.

With regard to cabinet responsibility, Mr Curphey seems to believe that RPSGB Council members who are strongly opposed to a Council decision should somehow be held responsible for it. This is just not logical: to go after the eight council members who refused to support the petition would be akin to blaming the British victims of American friendly fire in the Gulf war for "being in the wrong place at the wrong time".

There is also the fact that the Council is not just a "cabinet" but the profession's "parliament" as well. It is entirely unreasonable to expect Council members who oppose the content of the proposed new Charter and the petition to the Privy Council – sent without members even knowing what was finally in the Charter – to change their minds and fall in tamely behind those who voted the other way. This would be to betray the very members who overwhelmingly voted them into office.

Mr Curphey suggests that those who oppose the Council need to "grow up about democracy" yet he cunningly ignores the democratic facts: that members have consistently opposed the kind of changes included in the Charter petition at two AGMs, at the SGM, in hundreds of letters to the pharmacy press and not least through the electoral process. The very same democratic process that elected three SOS candidates to the Council while Mr Curphey was comprehensively trounced.

None of the pharmacists who voted for the proposed draft Charter was left with a mandate to turn the Society into little more than a regulatory body. Whereas the SOS candidates campaigned, and were elected upon the basis that the Charter should not be weakened. To a man, they voted against the Council's current proposals.

It is only because, like Mr Curphey, 16 members of Council have chosen to ignore all of these democratic processes and have gone ahead with the petition anyway, that the Save Our Society campaign has been left with legal action as the only effective option.

One question we may well ask is exactly where is the beefed-up Charter that Mr Curphey is talking about? Is it the one that has dropped the object of safeguarding and promoting the interests of the members in their exercise of the profession of pharmacy? Is it the one that would allow new categories of membership to be added without the members' express permission? Is it the one that waters down the checks on the Council that the membership currently enjoys? If so, it is the one that has just been sent to the Privy Council.

Rather than calling for the High Court action to be withdrawn, Mr Curphey should be calling on the Council to withdraw the petition for a new Charter. We do, however, agree with one of Mr Curphey's points: the need to get around the table and search for a solution that the members can support. This is something that the SOS has consistently offered and Lambeth consistently refused. We are delighted that Mr Curphey has "got the message"; let us hope he has persuaded his council colleagues.

Our door is always open; let us hope that Mr Curphey and his friends on Council will now walk through it.

Graham Phillips, Hassan Argomandkhah, Mike Williams, Mark Koziol, for the Save Our Society Campaign.

The Avicenna website is to host advice and model Standard Operating Procedures on its website for members. Speaking at the recent Avicenna conference, Michelle Styles, head of information at the NPA (inset picture) outlined how SOPs can help in improving quality, consistency, minimising risks & litigation and facilitating delegation to technicians. The NPA is currently working on SOPs on methadone, needle exchange, and CDs

Why Hull has given money to the SOS campaign

Much has been written about modernisation, the draft new Charter, the work of the RPSGB Modernisation Steering Group and the Save Our Society Campaign. So much so perhaps that some pharmacists are switching off – or were not turned on in the first place. However, in the Hull and East Riding area there has been much interest and debate. Rightly these are seen as vitally important issues for the future of our profession.

In January the committee of the Hull Pharmacists' Association – a fee paying membership organisation established in 1865 – balloted all its members. It sought their views about supporting financially the SOS legal campaign. It recommended support for three reasons:

- insufficient Council support for the new Charter petition
- lack of an SGM or ballot of members in support of the new Charter petition
- concerns over the effect the 'regulatory' objects would have on the representational functions of the Society.

The results of this were outstanding. Of the 59 members of the Association, 33 registered an opinion. Thirty two supported the motion and there was one registered abstention. Not one pharmacist in the Association who expressed an opinion believed that the SOS Campaign was wrong and did not want to support it financially.

Why, you might ask, is this significant? There are many reasons why pharmacists in the Hull and East Riding area can be justifiably proud of their contribution to the development of our profession. The establishment in 1995 of the first Pharmacy Development Group and the numerous examples of collaborative working with local Trusts and other health professionals on innovative pharmacy schemes amply demonstrate the area's claim to be a centre of excellence for pharmacy.

I believe that the Society should be very concerned that this group of pharmacists, who are passionately committed to developing our profession, are just as passionately opposed to its seemingly slow and inexorable drift to a regulatory-only role. The SOS legal challenge on Council members is being led by four named pharmacists, but as the ballot in our area showed, it has the support and backing of many more.

Graham Hill, Professional development pharmacist, East Riding and Hull LPC.

Dr Mike Mead explains the rationale behind managing the post-myocardial infarction patient

After an attack

THE COLLEGE OF PHARMACY PRACTICE
This course (module 1296), in association with multiple choice questions being published in C&D April 3, provides one hour's continuing education

- To be able to offer lifestyle advice to these patients
- To know which drugs should be used post-MI
- To be aware of the evidence base for these drugs
- To be aware of the side effects of post-MI drugs
- To know the targets for cholesterol and blood pressure

About 4 per cent of men and 2 per cent of women have had a myocardial infarction. There are about 820,000 men living in the UK who have had a myocardial infarction and 390,000 women, giving a total of over 1.2 million.[1] The principles of managing post-MI patients are well understood and evidence-based and the pharmacist can have a major impact on patient care in this area. There are eight key areas in managing the post-MI patient.

Smoking cessation

About 20 per cent of deaths from coronary heart disease in men and 17 per cent of deaths from coronary heart disease in women are due to smoking, but over a quarter of the population still smoke.[1] Stopping smoking is a key agenda in the post-MI patient and, increasingly, primary care trusts are adopting anti-smoking policies. Encouraging patients to stop smoking is a duty for all healthcare professionals.

Advice on diet and losing weight

Obesity is an increased risk for suffering an MI. The risk of a myocardial infaretion for an obese woman is 3.2 times that for a lean woman of the same age and for a man the relative risk is 1.5.2 Obesity is defined on the basis of the Body Mass Index:

$$\text{BMI} = \frac{\text{Weight in kilograms}}{(\text{Height in metres})^2}$$

In England about 45 per cent of men and 34 per cent of women are overweight (BMI 25–29.9) and an additional 20 per cent of men and 19 per cent of women are obese (BMI 30 and over).[1]

It is not just losing weight that will benefit a patient – changing to a low-fat diet rich in fruit and vegetables is also important. Increasing fruit and vegetable intake from two to seven portions a day will also lower blood pressure by about 7/3 mmHg. A low salt diet may be useful in patients with high blood pressure and we recognise the benefits of increasing intake of omega-3 fatty acids in the form of oily fish (herring, kipper, maekerel, salmon, trout, pilchards and sardines). To have a protective effect for heart disease you need to eat two to three portions of oily fish a week but once you have had an infarct you need a fatty fish meal daily (but toxins such as mereury in the fish we eat negate some of the protective effect).

Studies have shown the cardiovascular benefits (particularly in reducing cardiovaseular events post-MI) of eating a Mediterranean diet, that is, a diet rieh in fruit and vegetables, antioxidants, olive oil, polyunsaturated fatty acids, rapeseed-based margarine, fish, fibre, cereals, red wine, and poultry instead of red meat.[3]

Pharmacists should have a range of diet sheets, particularly low fat, available in their pharmacies. (A good source is the British Heart Foundation, tel: 020 7935 0185.)

Advice on exercise

Physieal inaetivity doubles the risk of coronary heart disease. Over

Continued on page 22 ▶

A little drop of what does you good – a small amount of alcohol protects against heart disease

one third of adults in the UK are inactive, taking less than one occasion of 30 minutes activity weekly.[1] Aerobic exercise should be encouraged for post-MI patients, within the limits of their symptoms. Increasingly PCTs are supporting "exercise on prescription" initiatives in conjunction with local fitness centres.

Alcohol

Alcohol intake up to three units per day protects against heart disease. Above this level the risks outweigh the benefits. Alcohol problems were covered in a recent article (*C&D, Pharmacy Update, December 13, 2003, p21–3*).

Lowering blood pressure

Hypertension is an important risk factor for MI and we should aim to achieve a blood pressure of 140/85 mmHg or less as a minimum. Even this is double the cardiac risk compared with a blood pressure of 125/75 mmHg. People with diabetes should have their blood pressure lowered to 140/80 mmHg or less. Patient centred information material on blood pressure and how to control it (including self-help) can be obtained from the Blood Pressure Association (*www.bpassoc.org.uk*, tel: 020 8772 4994), to where the patient can be directed.

Cholesterol

The NSF for coronary heart disease standard is to lower serum cholesterol to either less than 5mmol/l (LDL cholesterol to below 3mmol/l) or by 30 per cent, whichever is greater. This is now obsolete advice – every MI patient will benefit from a statin (*see below*). Diet only reduces serum cholesterol by an average of about 6 per cent, although it is still worth advising a diet low in saturated fat.

Controlling diabetes

Mortality rates are higher and coronary heart disease more common in diabetics than non-diabetics. It is most important to target all the inherent cardiovascular risks of diabetes – HbA1c (aiming for 7 per cent or less), blood pressure (aiming for 140/80 mmHG or less) and dyslipidaemia (targeting HDL cholesterol to above 1.2 mmol/l and triglycerides to below 2.3 mmol/l as well as LDL cholesterol to below 3mmol/l).

Prescribing the 'post-MI' formulary

There are five specific drug interventions that trial evidence supports in prescribing for patients post-MI.

Aspirin. Aspirin reduces the death and reinfarction rate by 25 per cent.[4] The usual dose post-MI is 75–150mg. Many patients say they can't take aspirin, but, such are the benefits, it is important to encourage its use, even if some patients need co-prescription of a proton pump inhibitor. Checking that post-MI patients are, or have at least been considered, for aspirin is a key issue. Patients truly intolerant of aspirin should be considered for clopidogrel.

Beta-blockers. Beta-blockers are used post-MI to reduce mortality by up to a quarter and re-infarction by up to a third.[5] Beta-blockers prevent arrhythmias and reduce sudden death.

There is no current recommendation on using one beta-blocker in preference to another, although bisoprolol and carvedilol are licensed for heart failure treatment so are the choice for post-MI patients with heart failure. There is evidence for the benefits of beta-blockers long-term post-MI and they should be continued indefinitely (although about a quarter of patients suffer adverse effects with beta-blockers, such as bronchospasm, bradycardia, impotence, fatigue, insomnia and cold hands and feet).

ACE inhibitors. For patients who are post-MI with left ventricular dysfunction there is a solid body of evidence that ACE inhibitors reduce death, hospitalisation and recurrent MI.[6,7] There is also evidence for their benefit in post-MI patients without heart failure. In both the HOPE study and the EUROPA trial, ACE inhibition – with ramipril or perindopril respectively – reduced major vascular events, including MI, by a quarter and a fifth respectively.[8,9] Over half of the patients in both studies had a previous MI without any evidence of heart failure. Although in both cases there was a slightly lower blood pressure in the ACE inhibitor group, it is thought that much of the outcome resulted from a cardioprotective effect of ACE inhibitors over and above a blood pressure lowering effect. Doctors are now adopting the policy of using ACE inhibitors routinely post-MI in all patients.

Statins. The Heart Protection Study has changed the way we think about statin prescribing.[10] This study of UK adults aged 40–80, each with total cholesterol greater than 3.5 mmol/l and a substantial five-year risk of death from coronary heart disease, randomised patients to simvastatin 40mg or placebo and followed the patients for five years. Nearly half were post-MI patients. Simvastatin reduced major vascular events, including MI, coronary death and stroke by about a quarter. After allowing for some non-compliance in the study, the final estimate of benefit was that simvastatin 40mg probably reduces the vascular event rate by about a third. Interestingly, this protective effect was independent of age, sex or total cholesterol level. The benefits were additional to the effect of aspirin, beta-blockers and ACE inhibitors. During the first year the reduction in the vascular event rate was not significant – it takes a year for this effect to be observed but the benefits then increase with time, the longer the treatment the greater the benefit. This emphasises the crucial importance of encouraging all patients to continue with their statin!

In summary, all post-MI patients with total cholesterol over 3.5 mmol/l (that is, virtually all UK patients) benefit from a statin. Other trials have shown that other statins reduce morbidity and mortality in patients with coronary heart disease.

Simvastatin 10mg is expected shortly to change from POM to P for patients at "moderate risk" of coronary heart disease.

Omacor. In September 2002 Omacor was launched as a P category drug with a licence for treatment post-MI in addition to other standard therapy. The evidence supporting its use comes from the GISSI-P trial, in which patients surviving an MI were randomly assigned to Omacor (1g daily of n-3 polyunsaturated fatty acids [omega-3 fatty acids] in the form of eicosapentaenoic acid [EPA] 46 per cent and

Inactivity doubles the risk of coronary heart disease. Aerobic exercise, as long as it is within the limits of the patient's symptoms, should be encouraged for post-MI sufferers

Continued on page 24 ▶

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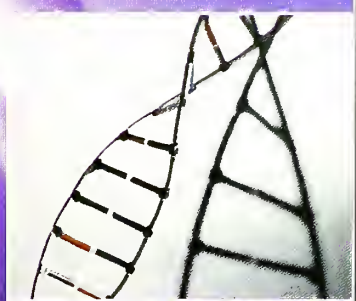

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Pharmacists practising in Northern Ireland will have their registration fee paid by the Northern Ireland Centre for Pharmacy Postgraduate Education & Training (tick box on registration form when applying).

Figures show that more than a third of UK adults take less than 30 minutes of exercise weekly

docasahexaenoic acid [DHA] 38 per cent), vitamin E, neither treatment or both.[11] Treatment with Omacor resulted in a 20 per cent reduction in all fatal events, a 30 per cent reduction in cardiovascular deaths and a 45 per cent reduction in sudden deaths. Giving vitamin E didn't reduce risk on its own or further reduce risk in combination.

Omacor produces its cardiac benefits through a variety of mechanisms including an anti-arrhythmic effect (important in preventing sudden death), an anticoagulant effect which is additive to aspirin, a triglyceride-lowering effect and a blood pressure lowering effect in patients with hypertension. The dose post-MI is one capsule a day and it can be prescribed with the other four agents (aspirin, beta-blockers, ACE inhibitors and statins).

Pharmacists' role

There is much the pharmacist can offer the post-MI patient – from advice on lifestyle and controlling specific risk factors, to checking that the patient has been considered for the five drugs with a secure evidence base for reducing morbidity and mortality post-infarction.

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Dr Mike Mead, a full-time GP in Leicester, is adviser to many medical journals, author of medical books and lecturer in medical matters in the UK and overseas. He is on the Healthcare Advisory panel of the Blood Pressure Association, and chairman of the ISSET group, which is dedicated to education and training on strokes.

Actionplan

1. Review the harmful effects of smoking so that when discussing MI/smoking with a patient you can include all the significant benefits of cessation.
2. Find out the current view of how significant salt reduction is with reference to blood pressure. What can patients do about it?
3. A recent report suggests farmed salmon contain toxic products. Find out as much as you can so you are able to provide up to date advice on eating such fish.
4. Revise the meaning of "units of alcohol". Note that three units a day exceed the recommended limit for females. Any thoughts?
5. What is HbA1c? How does this compare with the more common (in the home) blood glucose measurement?
6. *Which?* recently made adverse comments about pharmacists providing aspirin 75mg without adequate questioning of the patient. Revise the questions you need to ask with special reference to patients who may be at risk of an MI.
7. Do you stock Omacor? Should you? Find out more.

Learning for pharmacists

Readers using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C&D's readers can self-test their progress by using the multiple choice questions (MCQs) to be inserted in the April 3 issue, which will cover this week's CPP-accredited module. Questions will also appear in the March 13 and 27 issues. These will cover:

- **Post-myocardial infarction (1296)**
- **Hypokalaemia (1297)**
- **Cystic fibrosis (1298).**

A telephone [illegible] offers independent verification of results – details on the monthly MCQ papers. People wanting to [illegible] Pharmacy Update can contact Mary Prebble on 01732 377269.

Two products are best for RA

Two is better than one, at least when it comes to treating rheumatoid arthritis, researchers from the UK, USA and Europe have claimed.

Patients who used etanercept and methotrexate together experienced significantly greater benefit than those taking either treatment alone, claimed the study of 682 patients with rheumatoid arthritis published in *The Lancet*.

Over twice as many patients on the dual therapy (35 per cent) were in remission after one year than those on etanercept (16 per cent) or methotrexate alone (13 per cent). Patients who received the combination treatment were more likely to reach the response markers of reduction in symptoms set by the American College of Rheumatology of 20, 50 and 70 per cent. After one year of treatment, 43 per cent of patients on the combination treatment reached the highest market of ACR70, compared to 19 per cent of the methotrexate group and 24 per cent of the etanercept patients.

National Rheumatoid Arthritis Society chairman Ailsa Bosworth, said: "This is very exciting news indeed. It's fantastic that we are seeing one third of patients achieving remission in 12 months on the combination of etanercept and methotrexate.

"However, it is the improvement in radiological outcome and the fact that joint X-rays for the whole combination therapy group were better at one year compared with at baseline which I find fascinating. The future for people with RA is looking very much brighter."

For more information:

The Lancet 2004; 363: 675-81

Too much fluid can be harmful

"Stay at home and drink plenty of fluids" may not be the best advice for a cold after all, say researchers from Australia.

Taking on too much fluid during a cold can be dangerous and lead to irritability, confusion, lethargy, even coma and convulsions. This is due to salt loss and fluid overload, the authors of the paper in *BMJ* claim. Extra fluids consumed while the body has increased levels of antidiuretic hormone, found in adults and children with lower respiratory tract infections, can lead to hyponatraemia, which gives the physical symptoms, and fluid overload.

The researchers carried out a systematic review of existing studies of respiratory infections and looked at the fluid consumption of the study participants. They found four children died in one study with low serum sodium levels, and several studies had respiratory infection patients with hyponatraemia who were successfully treated with fluid restriction.

Salt loss and fluid overload can be a lethal cocktail

The authors recommend caution on advising patients to consume increased volumes of fluids, especially when they have a lower respiratory infection. However, they add, further research should be carried out to provide evidence that too much fluid can be harmful.

For more information:

BMJ 2004; 328: 499-500

Cholesterol drug explained

UK scientists have discovered how cholesterol absorption inhibitors work, with the identity of a protein called NPC1L1.

Ezetrol (ezetimibe) is the first in the cholesterol absorption inhibition class and is usually prescribed in conjunction with a statin. Previously, scientists were unsure of how it reduced cholesterol levels, but this research revealed that the NPC1L1 protein plays an important role in the cholesterol absorption pathway. The drug blocks the protein's action and this prevents cholesterol from being absorbed.

Consultant lipidologist at Guy's and St Thomas' Hospital in London, Dr Tony Wierzbicki, said: "While research in the past few decades has contributed much to our understanding of the production of cholesterol in the liver, this finding represents an important new discovery which helps to explain how the body regulates cholesterol absorption in the second clinical pathway – the intestine."

For more information:

Science 2004; 303: 1201-4

How stress affects heart

The cumulative effect of the mental and emotional stresses of daily life adversely affects heart health, claim US researchers.

High levels of negative emotions were linked to the heart's reduced ability to respond to stress, said the researchers at the annual meeting of the American Psychosomatic Society.

"While we have known that emotional stresses have been linked to the development and progression of coronary artery disease, it has not been clear why this is so," said author Dr Simon Bacon from Duke University Medical Center.

"What we have shown for the first time ... is that such negative emotions as anger, stress or sadness were associated with a reduction in autonomic control of the heart. These findings may help explain how acute stress may contribute to the increased risk of clinical events in patients with coronary artery disease," he said.

For more information:

www.dukemednews.org

Scriptlines

Distamine SPC change

The SPC for Distamine tablets (D-penicillamine 125mg and 250mg) has been updated and includes updated information on dosage and use in patients with renal insufficiency.

The SPC now recommends that patients should take Distamine on an empty stomach at least half an hour before meals, or on retiring.

Use in pregnancy or breast-feeding is not recommended. Concomitant use of NSAIDs is thought to increase the risk of renal damage.

For more information:

http://*emc.medicines.org.uk*

Alliance Pharmaceuticals

Tel: 01249 466966

Movicol for kids

Norgine has launched Movicol Paediatric Plain (6.9g sachet including 6.5g macrogol 3350, powder for oral solution) for treating faecal impaction in children two years old and over.

The dosage is as follows:

	2-4 years	5-11 years
	Number of sachets	
Day 1	2	4
2	4	6
3	4	8
4	6	10
5	6	12
6	8	12
7	8	12

Each sachet should be dissolved in 62.5ml of water (quarter of a glass). The dose should be taken throughout the day and the whole dose should be consumed within 12 hours. The dosage regimen should be stopped when disimpaction has occurred.

Adverse effects seen include abdominal distension and pain, nausea and mild vomiting. Mild diarrhoea and soreness have also been reported.

The product does not contain flavourings, sweeteners or artificial colours.

For more information:

See *Price List*

Norgine

Tel: 01895 825865

Canesten takes a dual approach to treating thrush

Women now have the "ultimate Canesten product" available to them, claims Bayer.

Canesten Duo combines Canesten Oral (150mg fluconazole) and the cream (2 per cent clotrimazole).

The 'P' pack offers women a quick acting capsule to treat thrush systemically, with a cream to soothe the itch.

Bayer's research suggests that 60 per cent of women want a thrush product that is easy to use and convenient but 50 per cent want a product that will quickly relieve the painful external symptoms.

The company is supporting the launch with a £5 million advertising campaign, including TV and women's press coverage.

Eye-catching point of sale material is available for pharmacies.

Price: £12.50

Pip code: 302-0328
Laser Healthcare
Tel: 01202 449700

Germoloids grows in size

Bayer is introducing Germoloids Cream in a larger size and relaunching its suppositories and ointment combination pack as Germoloids Duo.

The new 55g size of Germoloids Cream is suitable for frequent haemorrhoid sufferers. The cream is also available in a 25g size.

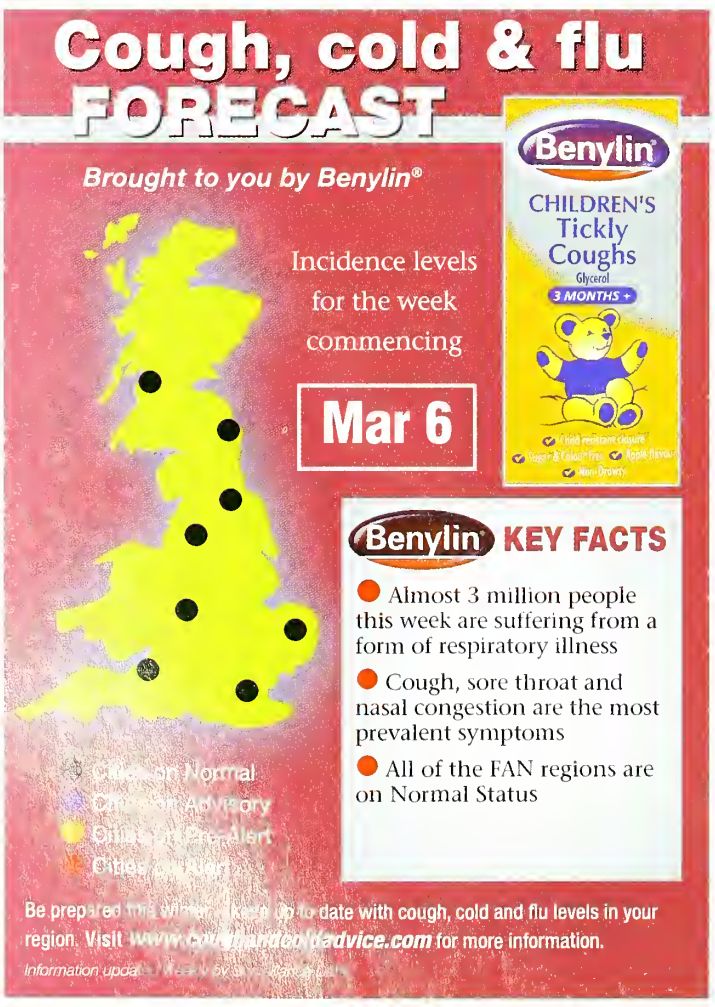
Germoloids Duo Pack contains a 15ml tube of ointment to lubricate and help soothe the pain and itching of external piles and 12 suppositories to help ease the painful swelling associated with internal piles.

New packaging is being introduced for the entire Germoloids range. Germoloids Cream, Ointment, HC Spray and Suppositories are now colour coded to make selection easier for customers.

New merchandising units are available to display the range.

Price: Germoloids Cream 55g £5.29, Germoloids Duo (12 suppositories plus 15ml ointment) £5.49

Pip code: Germoloids Cream 55g 302-0310, Germoloids Duo 281-1024
Laser Healthcare
Tel: 01202 449700



Pharmacy-only painkiller is a fast mover

GlaxoSmithKline Consumer Healthcare is launching a pharmacy-only 30 tablet pack of Panadol ActiFast.

The tablets contain paracetamol and sodium bicarbonate to promote stomach emptying and aid rapid absorption for fast pain relief.

Panadol ActiFast is the fastest growing variant of any major pain relief brand (brands worth £5million and over - Information Resources MAT Dec '03).

Price: £4.29

Pack size: 30 tablets
Pip code: 298-8335
GlaxoSmithKline Consumer Healthcare
Tel: 0825 762 6637

Mycota puts the boot in

Mycota athlete's foot remedy will be advertised at 10 rugby Super League games this year.

There will be two 1 metre x 6m signs in a prime position at each UK game. All the rugby matches will be televised by either Sky or the BBC.

A sports theme of 'Give athlete's foot the boot' will also be used in a new consumer leaflet, advertorials in the sporting press and at other sporting events throughout the year.

For more information:

Thornton & Ross
Tel: 01484 848200

Some things work faster

as a Duo*

New Canesten Duo combines the power of two fast thrush treatments in one: an oral capsule to resolve the infection and double strength cream for symptom relief. A fast response to thrush, in one convenient pack.

*Canesten Oral and Cream Duo works faster to relieve the symptoms of Thrush than Canesten Oral alone

Product Information for Canesten® Oral & Cream Duo. Presentation: ***Canesten® Oral Capsule*** contains 150mg fluconazole. ***Canesten Thrush Cream*** contains clotrimazole 2% w/w. **Indications:** ***Oral Capsule*** Treatment of candidal vaginitis, acute or recurrent. Also for treatment of partners with associated candidal balanitis. ***Thrush Cream*** Treatment of candidal vulvitis. To be used as an adjunct to treatment of candidal vaginitis. Can also be used for treatment of the sexual partner's penis to prevent re-infection. **Dosage and Administration:** *Adults (16 – 60 years):* Swallow one capsule. Apply cream to vulva and surrounding area two or three times daily and rub in gently. Treatment should be continued until symptoms of the infection disappear. If after concomitant treatment of vaginitis, symptoms do not improve within seven days, the patient should consult a physician. For treatment of sexual partner's penis, cream should be applied two or three times daily for two weeks. **Contra-indications:** Hypersensitivity to fluconazole, clotrimazole, related azole compounds or any of the excipients; co-administration with terfenadine or cisapride; pregnancy, suspected pregnancy and breast feeding. **Warnings and Precautions:** Adequate contraception necessary. A physician should be consulted if the patient or partner have had exposure to sexually transmitted disease, or if the patient has had more than two infections of thrush in the last six months; is experiencing thrush for the first time; has known hypersensitivity to imidazoles or other vaginal antifungal products, is taking any medicine other than the Pill; has any disease or illness affecting the liver or kidneys or has had unexplained jaundice, suffers from any other chronic disease or illness, is uncertain of the cause of symptoms. Or if the patient has any of the following symptoms: abnormal or irregular vaginal bleeding or a blood-stained discharge; vulval or vaginal sores, ulcers or blisters; lower abdominal pain or dysuria; any adverse events such as redness, irritation or swelling associated with the treatment, fever or chills; nausea or vomiting; diarrhoea; foul smelling vaginal discharge. In men, medical advice should be sought if: sexual partner does not have thrush; they have penile sores, ulcers or blisters; there is abnormal penile discharge; penis has started to smell; dysuria. Patients should consult their doctor if symptoms have not been relieved within one week. The cream may damage latex contraceptives so patients should be advised to use alternative precautions for at least five days. **Side-effects:** Nausea, abdominal pain, diarrhoea and flatulence. Rarely, rash, headache, hepatotoxicity and anaphylaxis.Cream may cause local mild burning or irritation immediately after use and hypersensitivity reactions. **Cost:** £12.50. **MA Number:** PL 00010/0282 & PL 00010/0077. **MA Holder:** Bayer plc, Consumer Care Division, Newbury, Berkshire RG14 1JA. **Legal Category:** P. **Date of Preparation:** February 2004

®RE[illegible] ARE TRADEMARKS OF BAYER AG

Canesten® can

Frontshop

Nivea reveals all for summer

Beiersdorf is expanding its Nivea Sun range with several new products for 2004.

Pampering Protection Mousse SPF8 and 15 is a new non-sticky mousse containing vitamin E.

Satin Sheen Sun Lotion has been introduced in SPF8 as well as the existing SPF15.

The Children's Sun Spray range of fun green coloured sprays is being extended with a higher factor SPF40 for children.

Sun Touch Self Tan Aerosol Spray and Self Tan Lotions for fair and normal skin are joining the existing products in the Nivea self-tan range. All the self-tan products include vitamin E and macadamia nut oil to aid smooth application.

The Nivea Sun range will be supported by a £1.8 million advertising campaign this year. Pampering Protection Mousse and Satin Sheen Lotion will be advertised on TV during May and July respectively. A cinema campaign for Sun Touch Self Tan Aerosol will target younger consumers during March and in August and September.

Price: Pampering Protection Mousse SPF8 (150ml) £11.75, SPF15 £2.99, Satin Sheen Sun Lotion (200ml) £9.99, Children's Sun Spray SPF40 (200ml) £14.95, Sun Touch range from £6.89

Beiersdorf UK Ltd
Tel: 0121 329 8800

Oxy goes to the movies

Oxy is coming to the big screen this month as part of a £930,000 support package targeted at teenagers aged 16 and over.

The campaign will be screened nationally across 2,000 Odeon and UCI cinemas from March 12 until April 26.

Two advertisements feature a good-looking boy whose attempts to chat up attractive girls are frustrated by an animated spot with a habit of saying the wrong thing at the wrong time. The advertising ends with the strapline 'Don't let spots ruin your chances'.

Further activity will come from a sticker campaign and a 'Text and Flirt' competition, targeting around 285,000 mobile phone users with the brand's new 'X' logo.

Point of sale material is available for independent pharmacies.

For more information:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Lingerie offer

Procter & Gamble has teamed up with online lingerie company Figleaves to launch a nationwide on-pack promotion for Alldays pantyliner.

Until April, Alldays packs will feature a £5 voucher that can be redeemed online at *www.figleaves.com* with a purchase of lingerie to the value of £15 or more.

For more information:
Procter & Gamble UK
Tel: 01932 896000

Promotion

Brand focus

Healthy heart – healthy life

The heart is a precious organ and is crucial to every function in the body, pumping oxygen rich blood throughout the arteries, veins and capillaries. To help maintain a healthy heart, diet, exercise and reduced stress levels play a vital role. However, high blood pressure, blood glucose, genetics, cholesterol, triglycerides and homocysteine in the blood can all increase the risk of heart disease and failure.

HealthAid CardiovForte™ has been specially formulated with powerful nutrients that are designed to support cardiovascular health, blood vessel function, circulation and contains key ingredients including Vitamin C, Proanthenols, Magnesium, Selenium, CoQ10, Soy Isoflavones, Carnitine, Arginine, Hawthorn Grape seed extract and Hawthorn berry, which over the years have been well documented to support cardiovascular function to help you keep a healthy heart and staying full of life.

CardiovForte™ is suitable for vegans and vegetarians, free from all common allergens and retails at £19.99 for 60 tablets. Please call **HealthAid** on **020 8426 3400** or visit ***www.healthaid.co.uk***

HealthAid

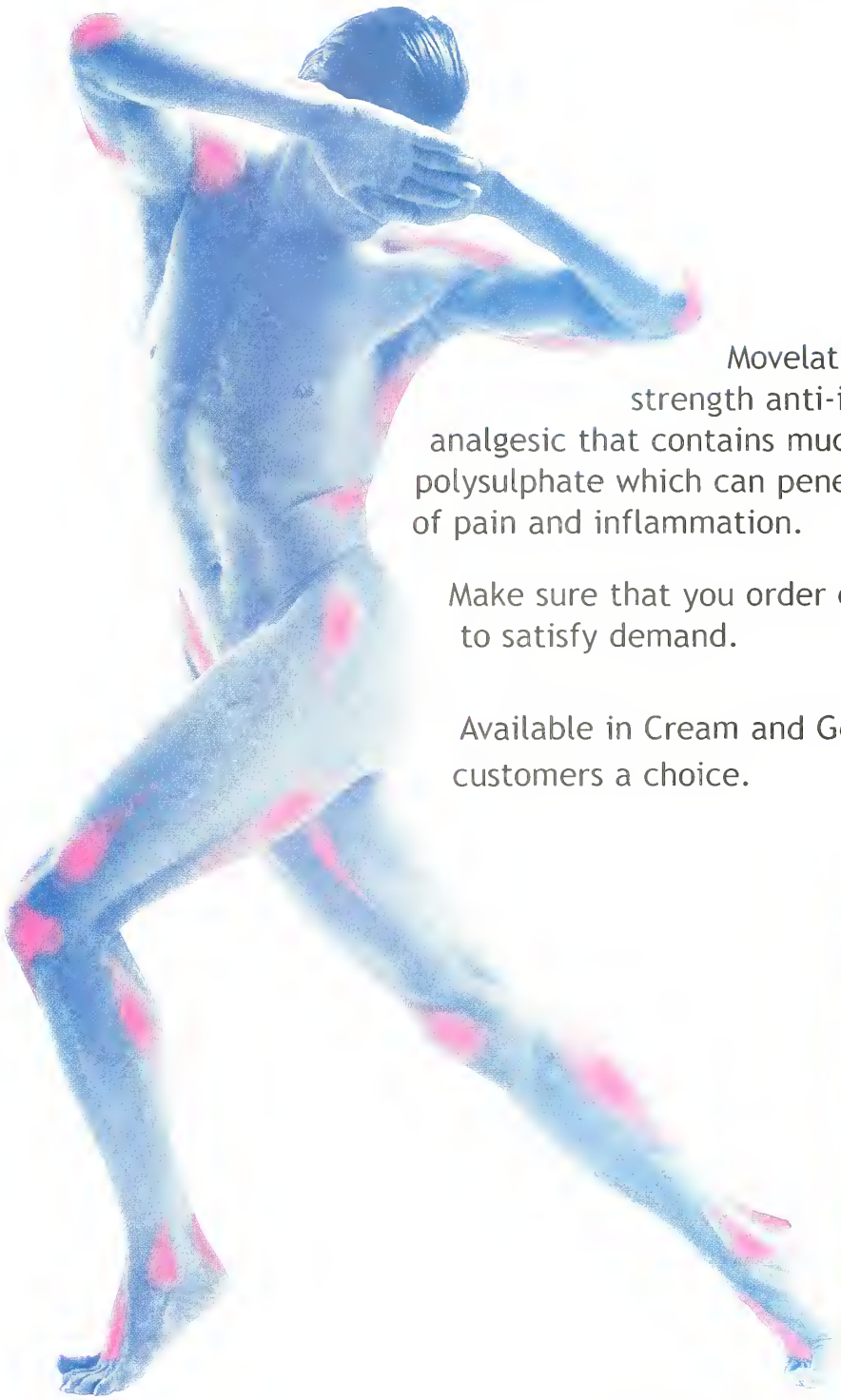
TV next week

Bonjela: C4, five, Sat
Califig: C4, Sat
Calpol: All areas except U, GMTV
Calprofen: All areas except U, GMTV
Huggies: All areas
Kalms: five, GMTV, Sat
Listerine: All areas except U
Nicorette: Sat
Olbas range: five, GMTV, Sat
Pepcidtwo: All areas
Rennie Soft Chews: All areas
Senokot: Y, C4, five, GMTV, Sat
Seven Seas Pure Cod Liver Oil: All areas except U, CTV, GMTV
Vagisil: All areas

PharmaSite for next week: NiQuitin CQ – window, **NiQuitin CQ** – in-store, **Canesten Oral & Cream Duo** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Pain relief at your finger tips



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Movelat Relief Gel/Cream. ABBREVIATED PRODUCT INFORMATION. **Presentation:** Movelat, Relief Cream contains mucopolysaccharide polysulphate (MPS) 0.2% w/w and salicylic acid Ph. Eur 2.0% w/w in a white cream base. Movelat, Relief Gel contains the same active constituents in a colourless gel base. **Indications:** Movelat, Relief is a mild to moderate anti-inflammatory and analgesic topical preparation for the symptomatic relief of muscular pain and stiffness, sprains and strains, and pain due to rheumatic and non-serious arthritic conditions. **Dosage:** Adults, the elderly and children over 12 years: Movelat, Relief Cream: Two to six inches (5-15 cm) to be massaged into the affected area up to four times a day. Movelat, Relief Gel: Two to six inches (5-15cm) to be applied to the affected area up to four times a day. **Contra-indications:** Not to be used in children under 12 years of age. Not to be used in susceptible asthmatic patients in whom salicylates can induce bronchial reactions. Not to be used on large areas of skin, broken or sensitive skin or on mucous membranes. Not to be used in patients with a known sensitivity to any active or inactive component of the formulation. **Pregnancy and lactation:** Not to be used during the first trimester or during late pregnancy. **Special warnings and precautions:** For external use only. The stated dose should not be exceeded. If the condition persists or worsens, consult a doctor. **Side Effects:** Allergic skin reactions may occur in individuals sensitive to salicylates. **Market Authorisation Holder:** Sankyo Pharma UK Limited, Repton Place, Amersham, Bucks. HP7 9LP. **Market Authorisation Numbers:** PL 8265/0008 (Movelat, Cream/Relief Cream), PL 8265/0009 (Movelat, Gel/Relief Gel) **Legal category:** P. **Trade Price:** £4.11 per 80g tube, £2.59 per 40g tube. **Retail Price:** £7.20 per 80g tube, £4.53 per 40g tube. **Further information from:** Medical Information, Sankyo Pharma UK Limited, Repton Place, Amersham, Bucks. HP7 9LP. **Date of preparation, API:** September 1997. **Date of revision, API:** February 2003. **Date of preparation,** February 2004.

MRF0403T SANKYO

Quitting comes of age

Fifty years ago the government officially recognised that smoking causes cancer; 29 years later the first No Smoking Day was launched and March 10 sees the initiative's 21st birthday. Asha Fowells reports

Next week's No Smoking Day will see an estimated 1.25 million smokers attempting to reduce the number of cigarettes they smoke or stop completely. The habit has become an increasingly important public health issue since the Government published the *Smoking Kills* White Paper in 1998 and is reflected in the £138 million the Department of Health has allocated to Stop Smoking services in England for 2003-06.

The level of investment has received praise from many people including No Smoking Day campaign director Ben Youdan. "The White Paper led the world in getting people to quit smoking and the UK has the best services in the world," he says. "The level of investment has been incredible and is creating an environment that supports smokers who are trying to quit as well as non-smokers."

The DoH is hoping that the massive investment will enable 800,000 smokers to quit for at least four weeks by 2006. Successful pharmacist-led schemes have a considerable role to play in helping PCTs reach their targets and are an important part of local smoking cessation services, says Mr Youdan.

"Deciding to give up smoking can be difficult and people may find it easier to go into a pharmacy they are familiar with than call a helpline," he says. He thinks the reason that pharmacy schemes have been so successful is pharmacists' commitment to staying up to date with new products and research.

All schemes should benefit from a new agreement between the DoH and the NRT manufacturers Pfizer, GlaxoSmithKline and Novartis. All PCTs will receive an allocation of free stock once the national prescribing of smoking cessation products passes a certain threshold. PCTs will then decide where the free stock is best used. It is envisaged that the amount of free stock supplied will be enough to help an additional 10,000 smokers in England.

The details of the agreements with the manufacturers have not yet been finalised, but Mr Youdan says: "It is easy to say that NRT costs less than smoking, but it just isn't that black and white. This agreement will make NRT much more accessible and is a very welcome move."

PharmacyHealthLink chief executive Miriam Armstrong praises the DoH's investment in smoking cessation services, although she would also like the Government to prove its commitment to public health by setting up a UK regulatory authority for nicotine and tobacco.

She thinks the quit targets set by the Government will only be achieved if pharmacists continue to be involved in service provision. "The quit figures for pharmacist-led services are very positive," she says. She highlights the need for pharmacists to receive the same training as all other health professionals to become smoking cessation advisors if they are to be considered part of the local quit services.

However, Ms Armstrong is a little more cautious about the free stock scheme, saying: "The money for this really needs to be coming from the general prescribing budget. NICE has said that NRT is one of the most cost-effective drugs that can be prescribed, so it shouldn't be dealt with separately. Smoking should be treated on the NHS like any other addiction."

Action for Smoking and Health (ASH) research manager Amanda Sandford is also unconvinced: "While it will encourage service providers to reach as many people as possible so they get more free stock, there are concerns

"The Government has to realise that maintaining quit services is more important than hitting targets"

Amanda Sandford

"Many people find it easier to go into a pharmacy they are familiar with than call a helpline"

Ben Youdan

hat four-week quit figures re not good enough. PCTs need to realise that it is not ust about getting as many patients through the services as possible, but following them up long-erm so they stay stopped. Twelve-month quit data is far more meaningful."

Nicorette is continuing its Fresh Start customer support programme and providing ongoing training

She has another concern about the DoH quit targets: "There is a feeling at grass-roots level that they are too ambitious. The Government has to realise that maintaining quit services is more important than hitting targets." The contribution of community pharmacists to these targets will continue to increase as long as they carry on getting the necessary support and resources. Ms Sandford thinks the profile of pharmacists needs raising and suggests highlighting pharmacy services during media campaigns in a similar way to helpline numbers.

So what of the future? GlaxoSmithKline NRT category manager Mark Dickinson says: "The market for smoking cessation products showed year on year growth of 12 per cent, making it the most dynamic OTC category. The lozenge market alone is now worth £8.8 million." He is quick to refute suggestions that the growth stems solely from GSL switches. "The higher number of GSL products available has helped visibility, but the majority of sales – around 70 per cent – are still through pharmacies."

Nicotinell brand manager Craig Shaw agrees: "The increasing number of GSL products is making the category much easier for patients to navigate, but pharmacists provide advice and support which empower patients to take control of their quit attempts. The category will continue to show extremely strong growth as patients become increasingly aware of self-care."

Nicotinell is continuing its placebo sampling programme throughout 2004 and is introducing a new merchandising unit and point of sale material. This, along with a simplified grid recommendation system, will enable customers to clearly understand what is available and help pharmacy assistants to offer advice. Nicorette is continuing its "Fresh Start" customer support programme and is providing ongoing training to pharmacists and assistants.

NiQuitin CQ brand manager Amardeep Kahlon adds that there is still huge scope for pharmacists to get more involved. "Eighty per cent of quitters go 'cold turkey' with no help from professionals or products. But it is a strong addiction and needs careful management otherwise people fail. Our figures show how many more people would benefit from help."

With everyone convinced that pharmacists have a huge role to play in encouraging people to give up smoking, an OTC market worth nearly £80m and growing, and the Government committed to the issue long-term, it seems that smoking cessation could be one service that will slot easily into the new pharmacy contract.

Nicotinell is continuing its placebo sampling programme throughout 2004 and is introducing a new merchandising unit and point of sale material

Demand increases for award-winning support service

Nilesh Shah proudly shows off his QUIT Smoking Cessation Supporter of the Year award

Pharmacist Nilesh Shah was delighted when he found out he had been named Smoking Cessation Supporter of the Year at the 2003 Quitter of the Year awards ceremony (*C&D, December 6, p42*).

Mr Shah has provided a smoking cessation service from Bells Pharmacy in Princes Risborough, Buckinghamshire since 1993 and proudly says that his first client has now been a non-smoker for 10 years. He estimates his quit rates as 70 per cent after four weeks, 63 per cent after 12 weeks and around 24 per cent after a year.

The first session lasts 30 minutes and involves the patient setting a quit date and drawing up a quit plan. Patients return to the pharmacy weekly for counselling, products and carbon monoxide monitoring for 12 weeks, then fortnightly until they have reached the six-month mark. Additional support is offered for up to a year.

NRT is provided for up to 12 weeks against prescriptions requested from the patients' GPs. Mr Shah submits a copy of the paperwork to the PCT after patients have been on the scheme for four weeks so a successful quit can be counted towards the PCT's target. For this he receives a £40 fee.

Close working relationships with his local surgeries means he gets many patients referred to his service by their GPs, as well as patients self-referring after seeing advertisements or hearing about the service from friends or family.

Mr Shah says that his success at the "Quitter of the Year" awards has raised the profile of his service. "The number of people coming into the shop has been unbelievable – I would say there has been a fourfold increase. I have had to go to an appointment system because of the workload, and have trained one of my assistants to fill in the paperwork and do the carbon monoxide monitoring."

Continued on page 33

Leicester pharmacy offers ad hoc quit advice

Pharmacists Eileen Taylor and Sue Patterson are not part of a smoking cessation project but this does not deter them from offering a smoking cessation service on an opportunistic basis.

The service is offered from Mason & Son pharmacy in Coalville, Leicestershire, to any patient who presents an NRT prescription or expresses an interest in quitting. The informal nature of the service means that patients drop in for advice and carbon monoxide monitoring as and when they want to. A 'smokalyser' has been provided by GlaxoSmithKline through its +Plus medicines support service.

"Patients can be very surprised by their carbon monoxide readings, and it acts as an added incentive to them when they are trying to give up smoking," explains Mrs Taylor. "It has made it more rewarding. People come in and tell us their achievements – from saving up the money they would have spent on cigarettes to buy a new motorbike, to being able to climb a hill for the first time in ages."

Despite receiving no funding for their efforts, Mrs Taylor says she would be reluctant to put the service on a more formal footing. "I think if we were part of a proper scheme we'd have to ask patients to make appointments during set 'clinic' times which isn't necessarily going to be convenient for them," she says, adding that the pharmacy's lack of consultation room would probably mean it wouldn't get accredited anyway.

The lack of funding also means that NRT is not supplied from the pharmacy, unless the patient buys the recommended product or requests a prescription from their doctor. Mrs Taylor says that some patients have experienced difficulties obtaining NRT prescriptions from their GPs in the past, but adds: "They seem to be finally realising that it is actually a very cost-effective thing to do."

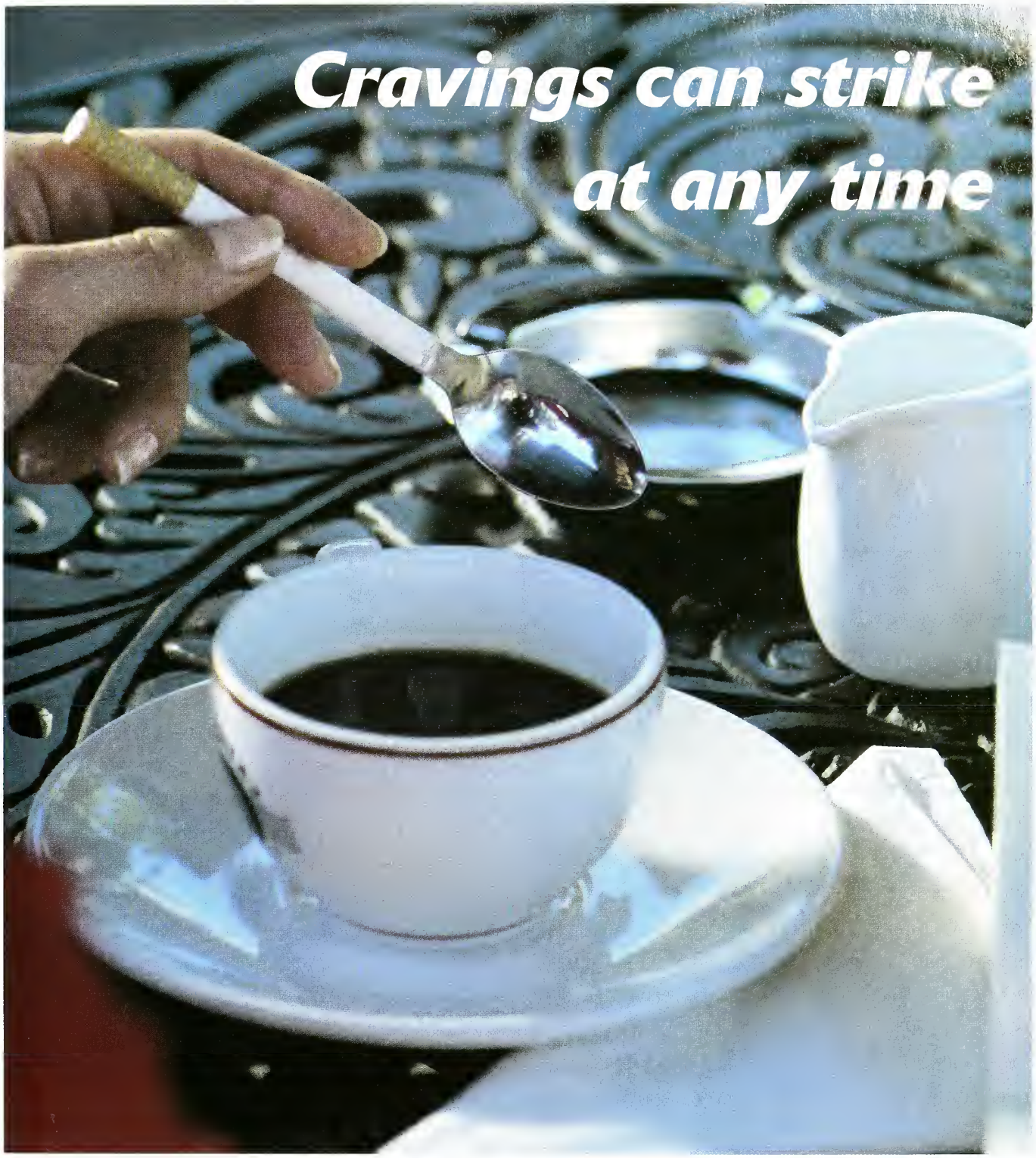
The first report on the impact of tobacco on reproductive and child health was published by the British Medical Association recently. The report estimated that:

- 120,000 men aged 30-50 are impotent as a result of smoking
- smoking is implicated in 1,200 cases of malignant cervical cancer every year
- smoking is linked to between 3,000 and 5,000 miscarriages every year
- women who smoke have 40 per cent less chance of conceiving per cycle than non-smokers
- men and women who smoke may have a poorer response to fertility treatment.

The BMA report findings are borne out by statistics provided by the organisation No Smoking Day, which says that one third of pregnant women in the UK smoke. These women give birth to babies on average 200g (8oz) lighter than non-smoking mothers. The charity also says that nearly 400 cot deaths a year are attributable to the mother smoking during pregnancy.

The BMA report supports the view that smoking has a longer term effect than on fertility alone. It presents new evidence saying that the risk of foetal malformations such as cleft lip and cleft palate is increased. Women who smoke are also more likely to experience problems with breast-feeding as they produce less milk that is of poorer quality.

Continued on page 34



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www.Click2Quit.com

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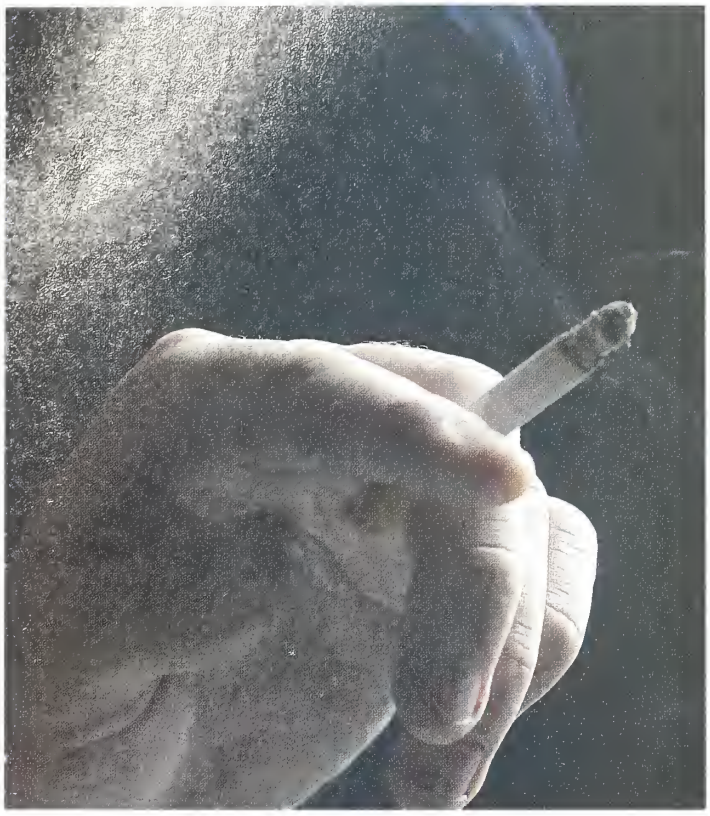
Product news



Launched last October, the Smokerlyzer System (£39.95) comprises a personal carbon monoxide monitor and a manual covering the three stages of the quit process (preparation, action and prevention of relapse) and advice on NRT and Zyban. The manufacturer claims that providing patients with visible evidence of declining carbon monoxide levels motivates them to persevere with their quit attempts.

From the end of March Smokerlyzer will be featured on the new Discovery Channel programme called "*Swimsuit Slim Down*" in which contestants are required to give up smoking as part of a makeover. Bedfont Scientific, tel: 01634 673720.

Honeyrose Products has launched a new advertising campaign for its range of herbal cigarettes and smoking mixtures entitled "Is Nicotine Locking You In?" Advertisements will feature over three months in trade and consumer health titles such as *Zest* and *Here's Health*. The company will exhibit at trade fairs including The Vitality Show later this month. Honeyrose Products Ltd, tel: 01449 612137.

GlaxoSmithKline recently teamed up with the London College of Fashion to try and change the perception that the fashion industry glamorises smoking. Over 100 students entered the NiQuitin CQ

The Smokerlyzer System is to feature on the new Discovery Channel programme *Swimsuit Slim Down*

Further information

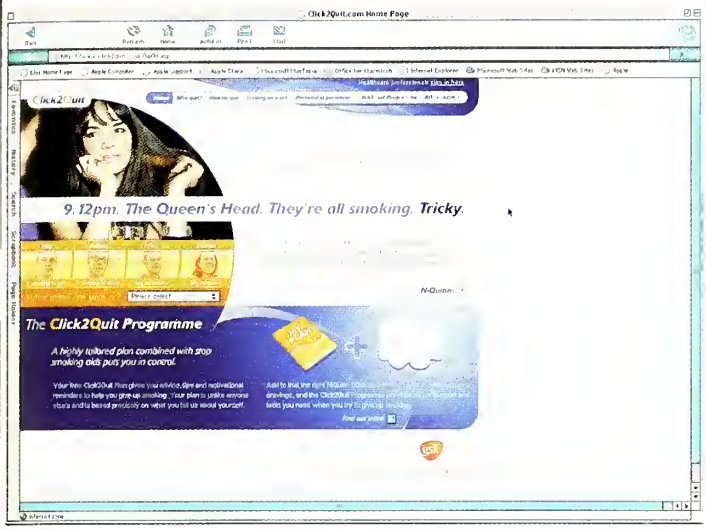
Action on Smoking and Health (ASH) can provide detailed information on government policy and reports.
Tel: 020 7739 5902
www.ash.org.uk

The No Smoking Day campaign can provide a range of resources for pharmacists providing smoking cessation support, including counter-top displays, posters, leaflets and campaign packs.
Tel: 0870 770 7909
www.nosmokingday.org.uk

QUIT can provide relevant literature suitable for both health professionals and the public.
Tel: 020 7251 1551
www.quit.org.uk

The NHS Smoking Helpline provides information for both health professionals and the public and helps locate local services.
Tel: 0800 169 0169
www.givingupsmoking.co.uk

The British Dental Health Foundation can provide resources to help make people aware of the oral health and mouth cancer issues associated with smoking.
Tel: 0870 770 4015
www.dentalhealth.org.uk



fashion awards that were judged by a panel of fashion industry and smoking cessation experts. Judge Ben Youdan of the charity No Smoking Day said: "Fashion has already played a key role in raising awareness of public health issues such as breast cancer, so it will hopefully inspire individuals to give up smoking."

The website *www.Click2Quit.com* was launched by NiQuitin CQ last December. Visitors to the site answer 60 questions to obtain a free individually tailored support plan. A study of nearly 3,500 smokers over 12 weeks showed that the website was more effective than standard untailored web material at preventing relapses during quit attempts, says GlaxoSmithKline. The company has also launched a range of "Power Postcards" to motivate quitters. The six cards provide tips on how to take control of every aspect of quitting smoking and are available free to pharmacists to distribute to their customers.

GlaxoSmithKline Consumer Healthcare, tel: 0800 358 3060.

The GSK Power Postcards are designed to motivate quitters

Facts and figures

Statistics provided by the No Smoking Day organisation show:

- Around 12 million adults in the UK smoke – 28 per cent of men and 26 per cent of women. This contrasts with 30 years ago when nearly half the UK adult population smoked.
- Smoking is highest among those aged 20-34 (38 per cent) and gradually declines, with the lowest smoking rate among people aged 60 and over (16 per cent).
- 20 per cent of women and 27 per cent of men are ex-smokers, showing that people do give up.
- Around 120,000 smokers in the UK die every year as a result of their habit.
- Smoking causes 30 per cent of all cancer deaths, 17 per cent of all heart disease deaths and at least 80 per cent of COPD deaths.
- Quitting before the age of 35 can reduce a smoker's health risk to that of a lifelong non-smoker.
- 74 per cent of UK smokers were aware of last year's No Smoking Day. Of those 12 per cent made a quit attempt.

Honeyrose's advertisements will feature over three months in trade and consumer health titles such as *Zest* and *Here's Health*

Building on the best

In December the Government published its views on how better use can be made of the NHS. Richard King reviews the implications and opportunities for pharmacy

Building on the Best is the wide-ranging report the Department of Health published in December 2003. It was based on the outcome of a widespread consultation process which started in August 2003 and was called "Choice, Responsiveness and Equity in the NHS and Social Care".

At its simplest level, the Government has in effect seen that NHS healthcare is a chicken and egg situation. "In a modern health service, responsiveness to patients and the ability to offer them real choices goes hand in hand with the better use of NHS capacity," it says.

Much additional real money is certainly being poured into the NHS to increase capacity (7.4 per cent extra in real terms every year from 2002-03 to 2007-08), an increase of some £40 billion per year by 2007-08. It is noted that while "without increased capacity, we cannot deliver the degree of choice that we want for patients" yet "unless we give patients the power to make real choices, we will not maximise the effect of the increased capacity we are creating".

As a classic example of the thinking the report embodies, a pharmaceutical example is quoted: "At its simplest we know that if patients are involved in discussion about the medicine they are prescribed, they are more likely to take it. The result is a healthier patient, and a resource [the drugs] actually being used."

The widespread consultation last year was aimed to find out what choices patients, NHS service users and carers typically want and what information such groups need in order to exercise their choices, while retaining fairness and equality of access.

The report includes many examples of existing good practice in empowering patients and giving them more choice, as well as making many proposals and revealing plans for change over the remainder of the present decade. This article will reveal some of the more interesting plans for the NHS, especially those that impact directly or indirectly on the world of pharmacy, and assess how feasible they are.

Giving people a greater say in how, where and when they are treated is one of six key themes in the report. One way of facilitating this is to give patients the opportunity to record their own treatment preferences in their own NHS care record via a secure web organiser called HealthSpace (*www.nhs.uk/healthspace*).

The implementation timetable for this service commences now by allowing patients to begin recording some basic information in their own "Healthspace". This will be followed in June 2006 with Healthspace linking to the complete NHS care record. One of several useful facilities of Healthspace will, for example, be the ability for patients to register for e-mail reminders to attend appointments, if they wish. Patients will also be able to see information about themselves building up by practitioners treating them, check its accuracy and make decisions over who else can see it.

The remaining five key themes in the report are:

- increasing choice of access to a wider range of services in primary care
- increasing choice of where, when and how to get medicines
- enabling people to book appointments at a time that suits them from a choice of hospitals
- widening the choice of treatment and care (starting with maternity services and choice of care at the end of life)
- ensuring that people have the "right information" about their health and the support they need to interpret and use it.

The remainder of this article will focus primarily on the "increasing access to medicines" theme; however, there is much of general interest in the report, which can be located on the DoH website (*www.dh.gov.uk*).

Increased choice in accessing medicines

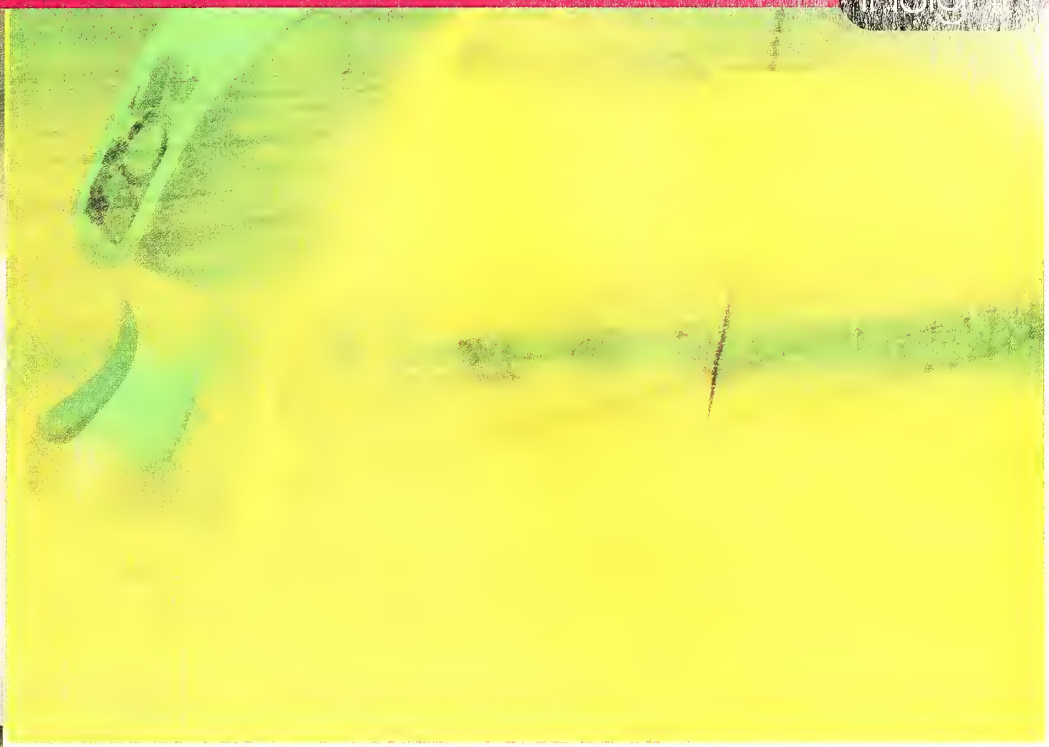
By the end of 2007 the electronic patient care record is expected to allow patients to collect repeat medications directly from any pharmacy. By implication this leaves just under four years to implement the national IT programme delivering electronic prescribing. This should give time for further trials of a chosen "finalised approach" before national implementation.

In my view this timetable does not look over-ambitious, as many pharmacists would like to see electronic prescribing and shared care records in less than four years and would therefore be supportive of working collaboratively towards this goal. The NHS investment increase already mentioned really should fund the NHS IT strategy, and fully embrace investment in IT for pharmacy.

The ability for patients to collect repeat medicines from one pharmacy of their choice is planned for December this year as part of the new contract arrangements. By implication, such rapid extension of the pilots nationally must anticipate using the same manual methods involved in the 30 PCT repeat prescribing pilots already running. To achieve national repeat prescribing by all pharmacies by the end of this year may be possible, but only, in my view, if the objective and benefits of getting there are very urgently communicated to everyone involved: GPs, pharmacists and patients alike.

The cost implications in pharmacy for this

"Giving people a greater say in how, where and when they are treated is one of six key themes in the report"



manual system are not great, but it is understood that there are presently problems with some GPs' IT systems to issue 12 contemporaneous repeats.

Other themes exposed in the report to "widen choice" relating to access to medicines are:

- freeing up the restrictions on the opening of new pharmacies
- freeing up the opening of internet and mail order pharmacies
- increasing the range of medicines which pharmacies can supply without a prescription
- increasing minor ailment-type schemes
- widening prescribing beyond nurses and pharmacists to optometrists and "some allied health professionals".

I will discuss these in turn.

Freeing up the restrictions on the opening of new pharmacies

The report says that Government wants to "offer patients more choice in where they get their prescriptions dispensed, which in turn will mean more choice of where they can get medicines for self-care, and to access the range of services that pharmacies will be providing in the future". It is noted that it is to be made easier for new pharmacies to locate in areas where consumers go, for example, large shopping developments, and for new pharmacies to open if they intend to operate for more than 100 hours a week. (Elsewhere in the report the useful role that inner city pharmacies provide is noted.)

Freeing up the opening of internet and mail order pharmacies

It is noted that some patients want their medicines delivered to their homes and that some pharmacies already provide such a service. The new national IT program will mean that internet pharmacies will be able to offer dispensing services to NHS patients. As the national IT program is not yet available, the report notes that in the interim it will be made easier for mail order pharmacies to offer such services.

Increasing the range of medicines and services pharmacies can offer without a prescription

The consultation leading to the report highlighted patients' desire to "take more direct control and responsibility for managing their own healthcare". The report says that therefore it is time to raise the pace of change in this area and wherever it is safe to do so. This will make it simpler for patients to get treatments over the counter for conditions that have previously been regarded as strictly the preserve of the prescriber.

Examples such as smoking cessation and EHC are highlighted as services that the Government wishes to replicate "where patients can access products when they need them and take control of their own treatment, backed by the expertise of a pharmacist". Such wider roles for community pharmacy are therefore to be encouraged and paid for through the new contractual framework.

The proposed switch of simvastatin from POM to P is quoted as a major step in the Government's commitment to expanding the range of medicines available for self-medication towards longer-term, chronic conditions and preventative therapies.

A target has been set to double the number of deregulations from the recent average of five per year. Treatment areas named in the report for further such deregulation include:

- chronic migraine
- gastrointestinal conditions
- asthma
- pain management
- eye infections.

Undoubtedly the industry will welcome these opportunities; it is to be hoped that excessive pricing strategies do not quash the opportunity.

Increasing "minor ailment" type schemes including provision for those who do not pay prescription charges

It is noted that the present arrangements unwittingly result in exempt patients frequently wasting the doctor's time and their own, for conditions that they might prefer to treat themselves with a medicine (if they could get it directly from a pharmacy). Twenty eight PCTs already have successful pharmacist-led minor ailment schemes that have resulted in GPs having more time to treat more serious conditions.

Pharmacists' skills have also been better utilised and patients have benefited. As a result the report states that all PCTs are expected to develop and pay for such schemes, as part of the new pharmacy contractual framework. National model service specifications and benchmark prices will be developed for their guidance.

Widening prescribing

The report notes that patients have already benefited from the quicker access resulting from nurse prescribing and that pharmacist prescribing is beginning this year. The goals of these developments are widening patient choice and making better use of the skills of professionals.

In summary all the above developments aim to make more choice a reality for patients by "cutting out red tape and rules that insist on people following particular routes to get their medicines".

This Government report pulls together several other recent ones and adds timescales where this was previously unclear. It is a matter of acute interest to our profession to see if there is sufficient political will and motivation to achieve change, to see these interesting proposals through to implementation.

Richard King can be contacted at: info@pharmacyconsulting.co.uk www.pharmacyconsulting.co.uk

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Carol'spharmacy

Little Monster we call him. He's so grizzly at the moment that when his teeth do finally come through, we're half expecting fangs! That gel my pharmacist recommended has definitely helped though. Thank goodness! Now if only they could rustle up something for his Daddy's wind...

Yourpharmacy

Where monsters are concerned, you're an angel. More than anything, that's because you're willing to take the time to dispense advice as well as treatments. Of course that means you could well find yourself going through nappy rash, sleepless nights and sticky eye all in the same month, but then having the chance to share customers' experiences is one of the things that makes community pharmacy so worthwhile. Of course the fact that you're part of an extended family of over 1,360 pharmacies helps too. It means Carol's not the only one who gets plenty of support.

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Miriam Armstrong

Steve Passmore

PharmacyHealthLink chief executive **Miriam Armstrong** has been invited to become a member of the Faculty of Public Health. The faculty acts as an authoritative body for consultation in public health matters and promotes advancement of knowledge in the field of public health.

IVAX Pharmaceuticals has announced the appointment of **Steve Passmore** as director of UK brands.

Previously UK brands head of sales, Mr Passmore will be responsible for the sales and marketing of IVAX's portfolio of respiratory products.

Kindhearted pharmacist pays for family's trip to Disney World

Mr and Mrs Savas of Whetstone, North London, were surprised and delighted when their local pharmacist, Ajit Shah, offered to pay for a trip to Disney World for them. Their daughter, Anastasia, has cystic fibrosis, and the family always goes to Oakleigh Pharmacy for her prescriptions and advice.

Mr Shah asked suppliers to contribute to the cost of the trip to Florida, but most refused, saying they only contributed to registered charities. But Mr Shah was not perturbed, and said he was willing to fund it himself.

The Savas family have said it is exactly what they need after a difficult few years. In addition to Anastasia being constantly in and out of hospital, Mr Savas had a heart attack a few years ago, and Mrs Savas's father died last year unexpectedly. Mr Shah said modestly: "God has given me plenty and I want to share it."

Unnat Patel with his latest donation to the local children's A&E unit

Toys donated to kids' casualty department

When Unnat Patel of Medicine Box Chemist in Leicester held a raffle for Cancer Research UK recently, the winner of the giant teddy bear asked him to donate the prize to the local children's casualty unit.

Mr Patel had already given two DVD/TV packages, a Playstation, several CD players and two Nintendo Gameboys to the recently opened department at Leicester Royal Infirmary.

Donating the bear along with two more Gameboys will take the outlet's total to nearly £1,000. The hospital is asking for £30,000 worth of new toys and donations.

Some 20 pharmacists and their partners were invited to a pre-match drink at Cardiff's Millennium Stadium by the wholesaler Phoenix prior to the first Six Nations rugby championship match. Pictured at the event on February 14 is Wendy Scarborough of Aneurin Evans pharmacy in Barry (right) with her husband Paul (centre) and Phoenix area manager Rhys Davis (left). The close-fought match saw Wales beat Scotland by 23 points to 10 – the perfect Valentine's treat for all Welsh attendees

Just as hard for chemystes back in days of Shakespeare

Guests at the Pharmaceutical Contractors' Committee's annual dinner last Friday were treated to some high culture as Patrick Slevin turned to *Romeo and Juliet*.

With several of Northern Ireland's paymasters among those attending, Mr Slevin highlighted Shakespeare's recognition of a profession in financial trouble even then.

As Romeo goes looking for some poison to end his woes, it is a holiday so "the beggar's shop is shut". He rouses the apothecary.

Romeo: "What, ho! apothecary!"

[Enter Apothecary.]

Apotheeary: "Who calls so loud?"

Romeo: "Come hither, man. I see that thou art poor."

Says it all really, doesn't it?

'Ring of fire' ad for piles a bum idea

Advertising executives thought they had hit on a sure-fire winner when they thought of using the Johnny Cash song *Ring of Fire* to promote Preparation H.

The idea was even backed by the song's co-writer Merle Kilgore, who said he had often joked about haemorrhoids when he introduced the song on stage.

But Johnny Cash's family has blocked the idea, calling it "crass" and "moronic". They say the song is about the "transformative power of love" and was inspired by the passion between the late Cash and his wife June Carter in the early stages of their relationship.

Allowing the drug company to use the song would have generated a huge amount of money for the singer's estate, but it appears the family does not want to make piles of cash.

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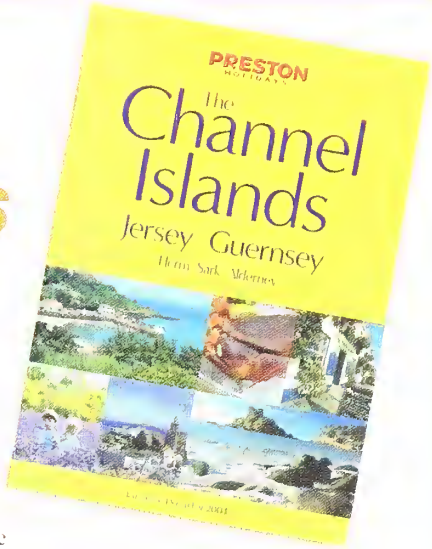

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Although world famous for its golden beaches and sweeping bays, Jersey offers visitors so much more. There's castles, museums, picturesque harbours, lush valleys, parks and shopping at duty free prices. Families are particularly well catered for and St Helier, the capital, boasts an excellent traffic free shopping precinct and a huge selection of restaurants and cafés. The standard of cuisine, liberally sprinkled with Jersey specialities, is excellent.

The jewels of Guernsey must surely be the wonderful golden sandy beaches stretching down the west coast which can treble in size at low tide. Rising steeply from its picturesque harbour St Peter Port, the island capital, looks out over the sister islands of Herm and Sark and the cobbled streets of its Old Town are home to shops, museums and restaurants.

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Reference:
1. Bakshi R, et al Curr Ther Res 1992; 52 435-442

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